



OPERATIONAL POLICY IN OBSTETRICS AND GYNAECOLOGY SERVICES

MEDICAL DEVELOPMENT DIVISION
MINISTRY OF HEALTH MALAYSIA



MEDICAL DEVELOPMENT DIVISION,
MINISTRY OF HEALTH MALAYSIA

This policy was developed by the Drafting Committee for Operational Policies of the Obstetrics and Gynaecological Services and the Obstetrics & Gynaecological and Paediatric Services Unit of the Medical Services Development Section, Medical Development Division, Ministry of Health Malaysia.

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DISCLAIMER

There are many variations in the design, location, facilities, support services and the presence or absence of subspeciality services in the hospitals managed by the Ministry of Health. There are also variations in human resources managing the obstetric and gynaecological services located in these hospitals in terms of numbers, experience levels, training and capability. There are numerous factors accounting for these variations, many of which are beyond the control of the Ministry of Health. These variable facilities and resources dictate that the same practices cannot be carried out in all hospitals at the current time.

The operating policies are practices which should be within the capability of most hospitals but not necessarily all. The policies outlined in this document will be aimed for by those involved in the O&G services of Malaysia. Efforts will be made by all concerned in the planning, operational activities and evaluation of such services to ensure that the majority of hospitals would be able to adhere to these policies and standards. However, it should be clearly understood that the operating policies listed here are not the minimum standards that should be found in all hospitals and should not carry any adverse inference in any hospital that cannot comply with these policies due to the reasons stated above. Hospitals will continue to be accountable for all the services that they provide in good faith for the benefit of the patients that they serve.

FOREWORD**DIRECTOR GENERAL OF HEALTH MALAYSIA**

Malaysia is proud of the strong foundations laid since independence in providing maternity services. The strategies of improving the access of pregnant mothers to healthcare, the professionalisation of the midwifery service by the enactment of the Midwifery Act, the commencement of specialist obstetric and gynaecological services which provided emergency obstetric care through a system of rapid, unhindered referrals, as well as the unique colour coding system of managing high risk pregnancies which emphasised the close cooperation between the health and hospital sectors, were successful in improving healthcare delivered to the pregnant woman such that her risk of dying in childbirth fell from 580 per 100,000 deliveries in 1950's to 30 per 100,000 deliveries in the year 2008 (Department of Statistics, Malaysia). This remarkable achievement would not have been possible without the political commitment in improving the status of women in this country.

We have now entered the consolidation phase of quality improvement activities and our emphasis is on patient safety rather than just an outcome-based approach in our thrust towards better patient care services. Obstetric services were at one time criticised for the lack of adherence to evidence-based practice. This was at a time when enemas were routinely given in labour and episiotomies were a matter of norm. To their credit, the

obstetric services are now very much evidence driven, based on randomised controlled trials, as found in the Cochrane database on perinatal care. The obstetric services are heavily utilized with 462,995 admissions in 2006 and 348,351 deliveries occurring in public hospitals.

Operational policies are imperative therefore in ensuring a uniform delivery of quality services. The obstetric and gynaecologic services have now developed a set of standard operational policies, covering those features of operations that lend themselves to a definite or standardized procedure without loss of effectiveness. It is vital for these sets of instructions to be well-internalised by all the caregivers in the Obstetrics & Gynaecology (O&G) services of this country so that any patient seen by these health care providers will be managed in a uniform way, one that is efficient, safe and assures quality care without negating the principle of individualised clinical attention appropriate to the situation.

I am pleased that these sets of standard operating procedures conform to the highest international and national standards of hospital accreditation bodies. We must always strive for excellence and I congratulate the team that has developed these standard operational policies, for leading the way in conforming to international standards.

I hope these Operational Policies of the O&G Services of Malaysia will form another milestone in the advancement of this specialty in Malaysia.



TAN SRI DATO' SERI DR HJ MOHD ISMAIL MERICAN

Director General of Health, Malaysia

FOREWORD**DEPUTY DIRECTOR GENERAL OF HEALTH (MEDICAL)**

Obstetrics and Gynaecological services are one of the core services in any hospital in this country. Nearly half a million women get admitted to both the obstetric and gynaecologic wards in this country annually. The care provided to these women has advanced from just inpatient care to ambulatory care in a significant proportion of patients in tandem with the development in other specialties.

Multidisciplinary care has also formed an integral part of the O&G services with the provision of combined clinics, formation of high dependency wards and the management of high risk obstetric patients with the input of intensivists and cardiologists.

Despite these advances, there are many challenges to be faced to ensure the good deliverance of services. The availability of operational policies will provide guidance to all concerned on the development of an efficient, evidence based and equitable system to provide obstetric and gynaecological services. It will also assist the Ministry of Health in the formulation of policies, planning for upgrading and new facilities as well as ensuring that available resources are utilised optimally.

It is noted that these operational policies have taken cognizance of the highest international standards as well as national standards for the accreditation of hospitals. The speciality is to be congratulated to be the first to achieve this standard and setting the lead for the others in the Ministry of Health. I wish to congratulate the Medical Development Division for initiating and coordinating this effort. I also wish to commend Dato' Dr Ravindran Jegasothy for spearheading the drafting team and for securing the consensus of all specialists in the fraternity.

It is my hope that these operational policies of the O&G services will form a catalyst in spearheading the discipline to greater heights.



DATUK DR NOOR HISHAM BIN ABDULLAH

Deputy Director General Of Health (Medical)

Ministry of Health Malaysia

1.0 INTRODUCTION

- 1.1 Obstetrics and Gynaecology services are one of the major clinical specialty services provided by Ministry of Health hospitals.
- 1.2 As the biggest health care provider in the country, hospitals in the Ministry of Health play an important leading role in development and provision of obstetrics and gynaecology services in Malaysia.
- 1.3 Advancements in obstetrics and gynaecology and rapid development of subspecialties require the support of a comprehensive and efficient service to provide optimum care to the patient.
- 1.4 This policy document encompasses key areas such as organisation, human resource, standards in patient management, clinical governance and ethics.
- 1.5 This policy outlines standards in care, intents together with measurable outcomes in accordance to best practice and guidelines. In hospitals where these standards are not fully met, necessary steps need to be taken to meet these standards.
- 1.6 It is intended to guide health care providers, hospital managers and policy makers on the requirements, operation and development of obstetrics and gynaecology service in the Ministry of Health hospitals.
- 1.7 This policy shall be reviewed and updated every three years or earlier as the need arises.

2.0 OBJECTIVES

- 2.1 To provide diagnostic, curative and rehabilitative obstetric services that are appropriate, effective, adequate and comfortable to mothers requiring institutional care so as to ensure the safe delivery of babies in order to reduce infant as well as maternal mortality and morbidity.
- 2.2 To provide an efficient and effective service in an optimum environment to patients undergoing elective and emergency surgery so as to relieve suffering and achieve early recovery.
- 2.3 To provide diagnostic, curative and rehabilitative gynaecological services that are appropriate, effective, adequate and comfortable to patients requiring institutional care in order to raise the health status of the public.
- 2.4 To provide diagnostic and curative obstetric services that is appropriate, effective, adequate and comfortable for patients requiring specialist outpatient and follow-up care.
- 2.5 To provide diagnostic and curative gynaecological services that are appropriate, effective, adequate and comfortable for patients requiring specialist out-patient and follow-up care.
- 2.6 To provide effective counselling to all obstetrics and gynaecology patients to ensure that the care provided is patient-centred.
- 2.7 To provide collective care along with satellite hospitals in the various subspecialties of obstetrics and gynaecology.

- 2.8 To ensure that patient care in obstetrics and gynaecology ensures the highest order of patient safety, efficiency, justification for actions and meticulous treatment.
- 2.9 To ensure all verbal advice, counselling, treatment and management is well documented.

3.0 SCOPE OF SERVICES

- 3.1 Provision of Antenatal Care
- 3.2 Provision of Specialized Maternal Fetal Medicine Services
- 3.3 Conduct of Hospital Deliveries
- 3.4 Provision of Elective And Emergency Caesarean Sections
- 3.5 Provision of Postnatal Care
- 3.6 Provision of Initial Immunization
- 3.7 Provision of Bereavement Counselling
- 3.8 Provision of An Early Pregnancy Assessment Unit (EPAU)
- 3.9 Provision of General Gynaecological Services
- 3.10 Provision of Fertility Services
- 3.11 Provision of Gynaecology Services
- 3.12 Provision of Urogynaecological Services
- 3.13 Provision of Maternal- Fetal Medicine Services

4.0 COMPONENTS

- 4.1 Wards (Obstetrics, Gynaecology)
- 4.2 Delivery suite
- 4.3 Maternity Operating Theatre
- 4.4 Main Operating Theatre
- 4.5 Specialist Out-patient clinics that may include the following:
Early Pregnancy Assessment Unit (EPAU), Antenatal, Combine, Prenatal
Diagnosis, Postnatal, Bereavement, General Gynaecology, Reproductive
medicine, Gynae-oncology, Uro-gynaecology, Menopause, Menorrhagia,
Adolescent Gynaecology, Contraception

Table 1 - Components and Category of Hospitals

	State	Major specialis	Minor specialist	Without specialist
Obstetrics & gynaecology ward	☆	☆	☆	☆
Delivery suite	☆	☆	☆	☆
Maternity Operating Theatre	☆	☆		
Main operating theatre	☆	☆		
Specialist outpatient clinic	☆	☆	☆	
EPAU	☆	☆	☆	
Antenatal clinic	☆	☆	☆	☆
Combine clinic	☆	☆	☆	
Prenatal diagnosis	○			
Postnatal clinic	☆	☆	☆	☆
Bereavement clinic	☆	☆	☆	
General Gynaecology clinic	☆	☆	☆	
Reproductive Medicine services & Clinic	○			
Gynae-oncology services & Clinic	○			
Uro-gynaecology Services and Clinic	○			
Menopause Clinic	☆	☆	☆	
Menorrhagia Clinic	☆			
Adolescent gynaecology Services	○			
Contraception Services	☆	☆	☆	☆

☆ Availability of services

○ Intended hospitals

5.0 ORGANISATION

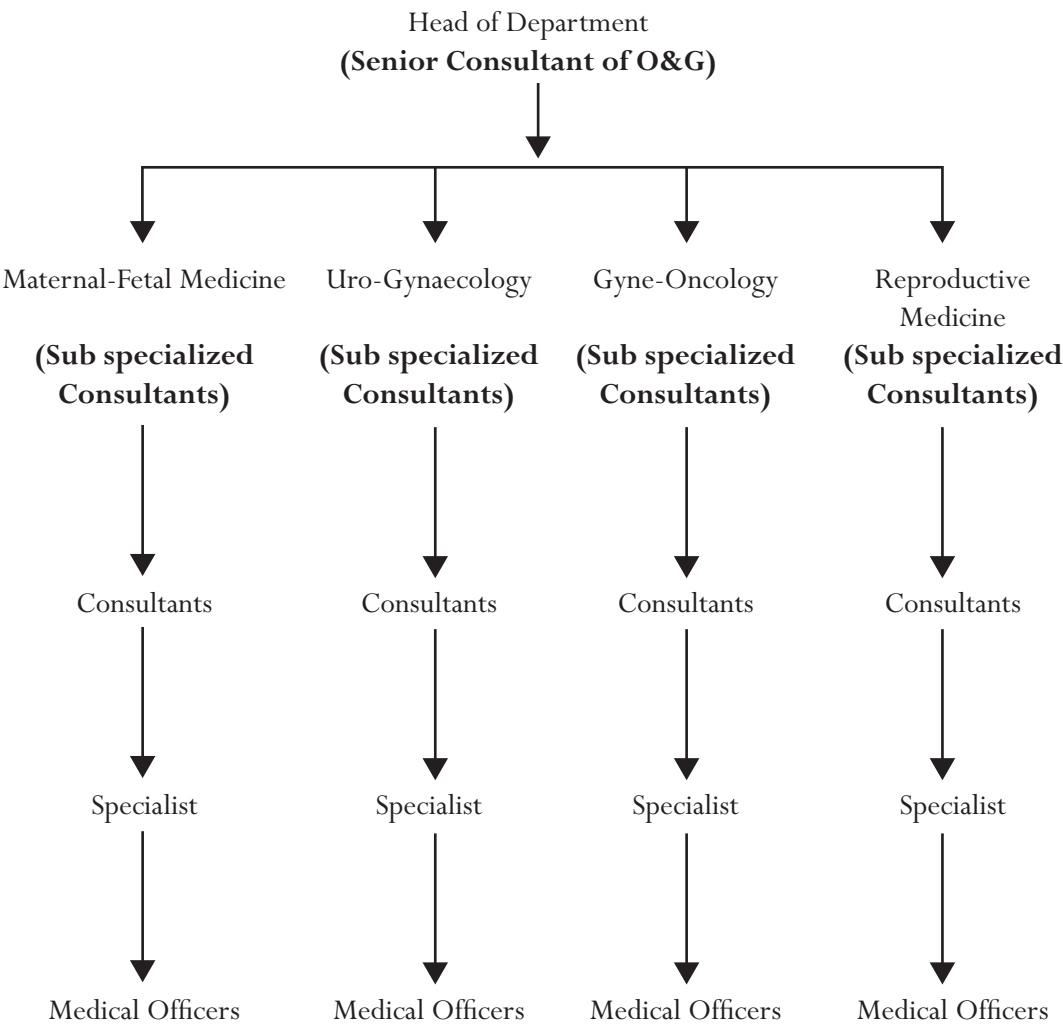


Chart 1 - Organization Chart of Obstetrics & Gynaecology Department

6.0 OPERATIONAL POLICIES

6.1 General

1. All referrals shall be in accordance with existing guidelines as stated in the “Garispanduan Rujukan” in the hospital.
2. Cases under police custody shall be guarded by the police.
3. All patients shall be supplied with four meals. Dietary guidelines produced by the Ministry of Health shall be followed.
4. Patient’s diet shall be indented “on-line” through the registration system (Sistem Pengurusan Pesakit Dalam) where available.
5. Patient’s meals shall be brought to the wards in bulk trolleys and plated at the ward pantry by the nursing staff.
6. All female patients examined by the male medical staff shall be chaperoned by a female staff.
7. An emergency trolley shall be made available at all times. The contents of trolley shall be checked regularly and replenished accordingly.
8. The Baby Friendly Policy shall be in practice. Breast-feeding shall be encouraged.
9. No infant Formula Milk Products samples shall be allowed in the ward. The “ Code of Ethics in relation to Infant Formula Milk (Tata Etika Susu Formula Bayi KKM 1995) ” shall be in practice.

10. Formula milk shall only be supplied upon request in writing and verified by the ward sister concerned.
11. Patients shall be charged according to the Fees (Medical) Order 1982.

7.0 PATIENT ADMISSION CENTER (PAC)

Standards

- 7.1 Pregnant patients are admitted to receive inpatient care based on their identified health care needs and the organization's mission and resources.
- 7.2 The department has a process for admission and for patient's registration.
- 7.3 Patient with emergency or immediate needs are given priority for assessment and treatment within 5 minutes of admission.
- 7.4 Patient's needs for preventive, palliative, curative and rehabilitative services are prioritized based on the patient's condition at the time of admission as an inpatient.

7.1 Standard

Pregnant patients are admitted to receive inpatient care based on their identified health care needs and the organization's mission and resources.

Intent of 7.1

- 1. The department should accept cases referred from the primary / secondary sources or 'walk in' cases for further pregnancy management of gestation more than 20 weeks.
- 2. All obstetric wards are integrated wards (combined antenatal and postnatal care).
- 3. 'Walk in' and referred patients need to be clerked, assessed and documented in patient's record at Patient Admission Centre (PAC) by house officer / medical officer. Any patients clerked by a house officer should be informed to a medical officer and the management agreed upon.

4. Admission shall be decided by the doctor after his/her assessment.
5. Patients in labour shall be admitted directly to labour suite / labour room and other patients will be provided a bed in the obstetric ward within 10 minutes of arrival.
6. Postnatal mothers referred from outside agencies or birth before arrival (BBA) within 24 hours shall be admitted directly to the obstetric ward together with their babies. Newborn babies with complications shall be admitted to the Paediatric Unit.
7. All patients for admission need to have an admission form (Borang Arahan Kemasukan Wad – JRP 3/94(Pin. 1/06) and must be registered at the Admission Registration Counter.
8. All patients for admission need to fill up an acknowledgment form regarding their valuables/ belongings (Borang Akuan Harta Benda Pesakit) at the Patient Admission Counter (PAC), including patients admitted from the antenatal clinic.
9. All inpatients shall be given a wrist identification tag and the babies would also be tagged accordingly.

Measurable elements of 7.1

1. Screening assessment(s) is initiated at the point of first contact time.
2. Based on the results of screening, the need of admission is decided.
3. Patients are accepted only if the department can provide the necessary services and appropriate inpatient setting for care of the patient.

7.2 Standard

The department has a process for admission and for patient's registration

Intent of 7.2

1. All patients for admission shall be given an admission form (Borang Arahan Kemasukan Wad – JRP 3/94(Pin. 1/06) and be registered at Admission Registration Counter.
2. All patients for admission need to fill up an acknowledgment form regarding their valuables/ belongings (Borang Akuan Harta Benda Pesakit) at the Patient Admission Counter (PAC).
3. All in patients shall be given an identification wrist tag (white colour).

Measurable elements of 7.2

1. Standard policies are used for inpatient admitting process

Percentage of patients not complying to admission procedures (Std: < 1%)

7.3 Standard

Patient with emergency or immediate needs are given priority for assessment and treatment within 5 minutes of admission.

Intent of 7.3

1. Patients with emergency or immediate needs such as severe preeclampsia, bleeding placenta praevia are assessed and receive care as quickly as necessary.
2. Patients who need further attention or with immediate need, should be informed immediately to the medical officer / specialist in charge of the PAC or the Specialist on Call.

3. Appropriate referrals to other department shall be made accordingly.

Measurable elements of 7.3

1. Staff shall recognize and prioritize patients with immediate needs.
2. Medical officer / specialist shall be informed immediately.
3. Patients are prioritized based on the urgency of their needs.

Emergency patients to be seen within 5 minutes by medical officer (Std: >95%)

7.4 Standard

Patient's needs for preventive, palliative, curative and rehabilitative services are prioritized based on the patient's condition at the time of admission as an inpatient.

Intent of 7.4

The assessment(s) by the medical officer will determine the type of inpatient services that are required for the patient either to obstetric wards, labour suite or high dependency ward.

Measurable elements of 7.4

1. The assessment(s) help the staffs understand and prioritize the service that is needed by the patient.
2. The service selected to meet these needs is appropriate

Inappropriate admissions rate (Std: < 1%)

8.0 OBSTETRIC WARDS

Standards

8.1 Access to care and continuation of care

- i. Each patient assessment(s) include an evaluation of physical, psychological, social and economic factors, including a physical examination and health history.
- ii. At admission as an inpatient, patient and families shall receive information on the proposed care, the expected outcome of that care, and expected cost to the patient for the care.
- iii. Reduce physical, language, cultural and other barriers to access and delivery of services.
- iv. In all phases of care, there is a qualified individual identified as responsible for the patient's care.
- v. The department provides continuity of patient care services and coordinates it among health professionals.

8.2 Medication management use.

8.3 Food and nutritional therapy.

8.4 Intradepartmental transfer of patients.

- i. Admission or transfer to or from units providing intensive or specialized services is determined by established criteria.

8.5 Discharge, referral and follow up.

- a. Discharge
Appropriate discharge of patients
- b. Referral
Appropriate referral of patients
- c. Follow-up
Patients and as appropriate, their families shall be given understandable follow-up instructions at referral or discharge.

8.6 Transfer of patients

Transfer for patient to another organisation for continuation of care.

8.7 Transportation

The process for referring, transferring, or discharging the patient considers transportation needs.

8.8 Death

Patients care in the department may end up or complicated with the death of the patient.

8.1 ACCESS TO CARE AND CONTINUATION OF CARE

All patients cared for by the organization have their health care needs identified through in established assessment process.

8.1.1 Standard

Each patient assessment(s) include an evaluation of physical, psychological, social and economic factors, including a physical examination and health history.

Intent of 8.1.1

1. The assessment(s) of patient provide the information to :
 - a. understand the care the patient is seeking
 - b. select the best care setting for the patient
 - c. form the initial diagnosis
 - d. understand the patient's response to any previous care
2. Relevant investigations to form the diagnosis shall be sent
 - a. Refer circulars on handling/ordering of lab investigations (Pengendalian Spesimen Makmal)
 - b. Ordering radiological investigations (Permohonan Pemeriksaan Radiologi)

Measurable elements of 8.1.1

All patients shall have an initial assessment in Patient Admission Centre / in the wards for the elective admission by the house officer / medical officer.

1. The initial assessment(s) results in understanding any previous care and the care the patient is currently seeking.
2. The initial assessment(s) result in selecting the best setting for the care.
3. The initial assessment(s) results in an initial diagnosis.

Inappropriate admissions rate (Std: < 1%)

8.1.2 Standard

At admission as an inpatient, patient and families shall receive information on the proposed care, the expected outcome of that care, and expected cost to the patient for the care.

Intent of 8.1.2

Patient and family shall receive sufficient information to make knowledgeable decision. Information is provided about above matters. When financial constraints related to the cost of care are present, the relevant authorities shall seek ways to overcome those constraints.

Measurable elements of 8.1.2

1. The staff and doctors shall provide the patient / family with information at admission on proposed care and the expected outcome.
2. Proper documentation shall be written in the patient's record regarding the information provided.
3. Patient shall receive sufficient information to make knowledgeable decisions.

8.1.3 Standard

Reduce physical, language, cultural and other barriers to access and delivery of services.

Intent of 8.1.3

The department serves communities with a diverse population. The staff shall be familiar with the barriers and try to reduce the impact of these barriers on the delivery of services.

1. All patients admitted shall be orientated on the facilities available in the ward and made aware of the rules and regulations of the hospital.

Measurable elements of 8.1.3

1. The staff in the department shall understand the important barriers especially the language especially in multiracial country and foreigners.

2. The staff shall try their best to overcome or limit barriers during the delivery of services, e.g using a translator.

8.1.4 Standard

In all phases of care, there is a qualified individual identified as responsible for the patient's care.

Intent of 8.1.4

In order to maintain continuity of care, throughout the patient's stay in the hospital, the individual with overall responsibility for the patient's care or particular phase of patient's care is clearly identified.

1. All new admissions from the clinic need to be clerked, assessed and documented in patient's records by house officer / medical officer in the wards.
2. All patients in ward need to be reviewed by house officer / medical officer within one hour.
3. All wards have identified consultant / specialist and medical officer in charge.
4. All patients admitted should be seen by the respective specialist at least once a day. On call specialist shall review the new cases in the ward.
5. House officer / medical officer shall do ward rounds three times a day.

Measurable elements of 8.1.4

1. The medical officer / specialist / medical officer responsible for the patient's care is identified.

2. The individual is identified to the department's staff by the department's roster and writing the names on the white board in the ward.

Patients seen by specialist during admission (Std: 100%)

Patients seen by doctor within 1 hour of admission (Std:>95%)

8.1.5 Standard

The department provides continuity of patient care services and coordinates it among health professionals.

Intent of 8.1.5

Several departments and services may be involved in providing care. The department shall implement continuity and coordination of care among physicians, nurses and other health care providers.

1. Interdepartmental referral shall be decided at the specialist / consultant level.
2. All interdepartmental referral shall have an input from the specialist / consultant.
3. Interdepartmental transfers shall be decided by the specialist.
4. The ward staff shall be informed regarding the transfer to coordinate and prepare the patient bed.
5. The referral ward staffs are responsible on the patient's transfer except for patients who are intubated will be transferred by the Intensive Care Unit (ICU) staffs.
6. All 'single mothers' shall be referred to the Medical Social Welfare Officer.

7. All notifiable diseases shall be notified to the Health Officer through the Medical Record Department within 24 hours.

Measurable elements of 8.1.5

1. Continuity and coordination shall be evident throughout all phases of patient care.
2. Continuity and coordination are evident to the patient.

Referrals are made at specialist level (Std: 100%)

Care plans of referred patients are decided at specialist level (Std: 100%)

8.2 MEDICATION MANAGEMENT USE

Refer Operational Policies for medication management use.

8.3 FOOD AND NUTRITIONAL THERAPY

Refer Operational Policies for food and nutritional therapy.

8.4 INTRADEPARTMENTAL TRANSFER OF PATIENTS

8.4.1 Standard

Admission or transfer to or from units providing intensive or specialized services is determined by established criteria.

Intent of 8.4.1

Antenatal cases:

1. The ward staffs are responsible for moving the patients within the department.
2. Patients shall be transported on mobile beds, wheelchairs or trolleys. Ambulant patients may be escorted on foot by the ward staff.

3. The ward's staff should inform the labour suite's staff regarding mothers who need to be sent to labour / delivery suite and responsible for transferring the patient. Labour suite staff shall transfer the patients back to ward after delivery.
4. Cases managed in the labour suite shall abide by the policies of the labour / delivery suite.
5. Cases requiring further attention and management in High Dependency Ward shall be decided at the specialist/consultant level. These cases shall abide by the policies of the High Dependency Ward.
6. The ward staff shall be responsible for transferring the patient from the bed to the Operation theatre and vice versa to ensure patient's safety.
7. Cases requiring surgery in the Maternity Operation theatre shall abide by the policies of the Operation theatre.

Postnatal cases:

1. Labour suite staff shall transfer patients and their babies from Labour suite to wards.
2. Labour suite staffs are responsible to transfer the babies that need to be admitted to Maternity Neonatal Intensive Care Unit (MNICU).
3. Newborns requiring neonatal intensive care shall be sent to the MNICU as soon as possible for further management after informing the parents.

4. On receiving the mother and baby, the ward staff shall check their tags to verify their identification – ‘Correct baby to the correct mother’. Ward staff shall go through the checklist that is available.
5. Patients who have a perinatal death shall be nursed away from other postnatal mothers in a ward with no babies and the mothers would be discharged home faster if they have no complications at delivery.

Measurable elements of 8.4.1

1. Established entry and / or transfer criteria for intensive care (High Dependency Ward / Maternity Neonatal ICU) or specialized services (Labour suite / Maternity Operation Theatre) shall be followed.
2. Patient who no longer meet the criteria to remain in the unit are transferred or discharged.
3. Newborns are tagged and transferred according to the operative procedures.

Compliance to baby checklist to assess identification (Std: 100%)

Immediate return of patients transferred intradepartmentally (Std: < 1%)

8.5 DISCHARGE, REFERRAL AND FOLLOW UP

Referring or discharging a patient to health care professional outside the organization, another care setting, home or family is based on the patient's health status and need for continuing care or services. The family is included in the discharge planning process as appropriate to the patient and her needs.

8.5.1 Discharge

Standard

Appropriate discharge of patients

Intent of 8.5.1

- i. Patients shall be charged according to the Fees (Medical) order.
- ii. No leave of absence shall be granted to patients.
- iii. Patients who wish to leave the hospital against medical advice need to do so in writing in an appropriate form.
- iv. The minimum length of stay for the uncomplicated postnatal primigravida mothers and their babies shall be up to 24 hours. For multiparas mothers, minimum stay should not be less than 12 hours.
- v. Postnatal patients with complications and delivered operatively shall be discharged appropriately (not less than 48 hours after delivery).
- vi. Mothers should have been able to pass urine before discharge. The newborn should have been able to pass urine and have their bowels opened before discharge.
- vii. Mothers shall be discharged together with their babies unless the babies require prolonged stay in the hospital.
- viii. Identification, verification of babies and relevant administrative matters / education, shall be carried out by the nursing staff before leaving the ward. A checklist shall be filled up.
- ix. Physically disabled and mentally incompetent patients shall be discharged to the legal custodian with written acknowledgement.

- x. The police shall be informed, through the hospital police counter, of any patient found missing, after all efforts to trace the patients have failed. Such cases shall be informed to the specialist, sister in charge and the Head of Department. Discharge shall be done after 24 hours of the patient being noted to be missing.
- xi. All discharges of antenatal and postnatal mothers shall be recorded in the antenatal card – ‘Home based antenatal card (Rekod Kesihatan Ibu) (KIK/1(a)/96).
- xii. Discharge summary for antenatal or postnatal patients should be done by house officer / medical officer. A copy of the discharge summary shall be attached to the antenatal card for the patient / the Health officers responsible for the patient’s continued and follow up care.
- xiii. Discharge summary shall include the following:
 - a. Reason for admission.
 - b. Significant diagnoses and co morbidities.
 - c. Diagnostic and therapeutic procedures performed.
 - d. Significant medications and other treatment.
 - e. The patient’s condition on discharge.
 - f. Discharge medication.
 - g. Follow up instructions.
- xiv. The medical records shall be dispatched to medical record department within 72 hours after the discharge.

Measurable elements of 8.5.1

1. Patient shall be appropriately referred and / or discharge.
2. Discharge summary shall be prepared at discharge by a qualified person, containing relevant information and follow up instructions, for patients and their practitioner responsible for the patient's continuation of care.

Dispatch of records to Records Office within 72 hours (Std: 100%)

Survey of patients to ensure clear discharge instructions (Std: 100%)

8.5.2 Referral**Standard**

Appropriate referral of patients.

Intent of 5.5.2

1. The department shall cooperate with health care practitioner and outside agencies to ensure timely and appropriate referral
2. A referral shall be made appropriately to other departments or for outside agencies if necessary
3. Interdepartmental referral shall be decided at the specialist / consultant level.
4. All interdepartmental referral shall have an input from the specialist / consultant.
5. A referral letter, containing the summary of the patient's problem and care shall be given to patient for the next practitioner.

6. Transport arrangement shall be made for transfer to other departments / hospital.

Measurable elements of 8.5.2.

1. Referral shall be made appropriately when necessary

Referral of patients at specialist level (Std: 100%)

8.5.3 Follow-up

Standard

Patients and as appropriate, their families shall be given understandable follow-up instructions at referral or discharge

Intent of 8.5.3

1. The name and location of sites for continuing care shall be informed to patient and family.
2. Appropriate appointment dates shall be given to patient if any return to for the services in the department is needed.
3. The instruction shall be explained to patient and family and provided in writing.

Measurable elements of 8.5.

1. Follow up instructions shall be provided in an understandable form and manner (verbal and written) to patient and / or family.

8.6 TRANSFER OF PATIENT

8.6.1 Standard

Transfer for patient to another organisation for continuation of care.

Intent of 8.6.1

Transferring of patient to outside organizations shall be based on the patient's status and need for continuation of care.

1. Transfer shall be made in response to a patient's need for specialized consultation and treatment or facilities such as ventilator.
2. Decision for transfer shall involve the specialist in charge.
3. An appropriate referral shall be made to the outside organisation verbally as well by writing (referral letter and discharge summary).
4. The patient have to be in stable condition and suitable for transfer.
5. An appropriate level of staff shall accompany the patient to the referral health care centre depending on patient's condition and requirement for monitoring.
6. A proper documentation shall be written in the patient's record regarding the name of the health care services, the name of the individual agreeing to receive the patient, the reason(s) for the transfer and patient condition before and during transfer.

Measurable elements of 8.6.1

1. Patient shall be appropriately transferred to other health care services.
2. Transfer process shall be documented in the patient's record.

Referral letter shall be in the medical records and show documentation that there was specialist input in the referral process (Std: 100%)

8.7 TRANSPORTATION

8.7.1. Standard

The process for referring, transferring, or discharging the patient considers transportation needs.

Intent of 8.7.1

Transportation for patient's transfer shall be arranged, depending on patient's condition and status.

Measurable elements of 8.7.1

1. The process of referring, transferring, and discharging patients shall consider transportation needs.
2. Transportation shall be appropriate to the patient's needs.

Transportation shall be appropriate to the patient's needs (Std: 100%)

8.8 DEATH

8.8.1 Standard

Patients care in the department may end up or complicated with the death of the patient.

Intent of 8.8.1

1. Death Certificate shall be signed immediately by medical officer and the accurate cause of death shall be written.
2. The next of kin shall be informed of patient's death, in the ward or via the hospital police counter if necessary and documented in the patient's record.

3. The parents shall be informed / counselled regarding perinatal death by medical officer/specialist and offered a post-mortem. The perinatal death format shall be filled up and sent to the Health Officer of the district concerned and a copy shall be kept in the department for future references.
4. The deceased shall be sent to mortuary within one hour for release to the next of kin or for post-mortem.
5. Any patient/mother who dies in the hospital shall be transported on a cadaver trolley to the mortuary by the mortuary attendants.
6. All maternal deaths shall be notified to the Health Officer immediately by the hospital maternal death coordinator. The relevant documents shall be documented by the specialist involved after the maternal mortality meeting, and submitted to the relevant authority within 2 weeks.

Measurable elements of 8.8.1

1. Patient's family / next of kin, shall be informed regarding the death appropriately and shall be documented in the patient's record.
2. Appropriate transfer of the deceased to mortuary shall be made appropriately.
3. A proper notification regarding the patient's death shall be made to the health officer.

Perinatal mortality rates

Maternal mortality rates

***Timeliness of death notification to the health district within 48 hours
(Std: 100%)***

9.0 LABOUR ROOM/SUITE

Standards

- 9.1 Admission to labour room/suite.
 - 9.1.1 Process of patient's assessment and admission.
- 9.2 Care of patient in labour room/suite.
 - 9.2.1 In all phases of care, there is a qualified individual identified as responsible for the patient's care.
 - 9.2.2 Procedures and activities in labour room / suite.
 - 9.2.3 Delivery by Caesarean Section / Procedure in Maternity Operation Theatre (MOT).
 - 9.2.4 Available policy / procedures guide for Red Alert.
- 9.3 Medication management use
- 9.4 Referral
 - 9.4.1 The department shall cooperate with health care practitioners/ other departments and outside agencies to ensure timely and appropriate referral
- 9.5 Discharge and transfer from labour room/suite
 - 9.5.1 Intradepartmental transfers are handled by staff nurse in labour room.
 - 9.5.2 Interdepartmental / other hospital transfer requested based on severity of illness or decided by the Specialist.

9.6 Death

9.1 ADMISSIONS TO LABOUR ROOM / SUITE

Standard

Process of patient's assessment and admission.

Refer Operational Policies for Patient Admission Centre (PAC) No: 7.1-7.4 and Obstetric Wards, Access to Care and Continuation of Care, No: 8.1-8.3

9.2 CARE OF PATIENT IN LABOUR ROOM / SUITE

9.2.1 Standard

In all phases of care, there is a qualified individual identified as responsible for the patient's care.

Intent of 9.2.1

In order to maintain continuity of care, throughout the patient's stay in the labour room / suite, the individual with overall responsibility for the patient's care or particular phase of patient's care is clearly identified.

1. All new admissions need to be clerked, reviewed, assessed and documented in patient's record by house officer / medical officer in the labour room / suite.
2. All patients need to be reviewed by house officer / medical officer immediately / as soon as possible.
3. The labour ward have identified consultant / specialist and medical officer in charge.

4. Management of all patients in labour ward / suite shall be supervised by the specialist / consultant.

Measurable elements of 9.2.1

1. The medical officer / specialist / medical officer responsible for the patient's care are identified.
2. The individual is identified to the department's staff by the department's roster and writing the names and contact numbers on the board in the labour ward admission counter.

Management at the labour ward is with specialist input (Std: 100%)

9.2.2 Standard

Procedures and activities in labour room / suite.

Intent of 9.2.2

Labour room / suite is a specialize area, taking care of mothers in labour. To ensure optimum patient care and safety to mothers and their babies, appropriate guidelines shall be followed for all procedures and activities.

1. During intrapartum period / postnatal period, refer to protocols :
 - a. Management of normal delivery: 'Pengendalian Kelahiran'.
 - b. Management of CTG: 'Pengendalian CTG'.
 - c. Management of the placenta: 'Pengendalian Uri'.
 - d. Vaginal examination: 'Proses pemeriksaan faraj'.
2. Ensure babies' safety.
 Refer 'Pekeliling Ketua Pengarah Kesihatan Bil 1 / 2007: Garispanduan Sistem Kawalan Keselamatan Bayi di Hospital-Hospital Kementerian Kesihatan Malaysia' (Guidelines on Safety of Babies in Ministry of Health Hospitals)

Measurable elements of 9.2.2

1. Procedures and activity is according to the guidelines available.
2. Baby safety checks done.
3. Protocols for management are followed.

Compliance to practice protocols (Std: 100%)

9.2.3 Standard

Delivery by Caesarean Section / Procedure in Maternity Operation Theatre (MOT).

Intent of 9.2.3

1. All caesarean sections shall be decided or discussed with the consultant / specialist in charge.
2. Patient's pre-operative preparation shall be done appropriately;
 - a. Consent from patient.
 - b. Patient's husband or next of kin shall be informed prior to the surgery.
 - c. Prophylaxis against aspiration in caesarean sections shall be given to patient.
 - d. Prophylactic antibiotics shall be given to patient in labour room / suite or MOT for Caesarean section, manual removal of placenta (MRP), etc.
 - e. Patients shall be put in Operation Theatre attire.
 - f. Maternity Operation Theatre (MOT) and anaesthetist shall be informed regarding case.
 - g. Patient shall be transferred to MOT on trolley by the labour room staff once patient is called to MOT.
 - h. Case shall be passed over to MOT staff and fetal heart rate shall be checked.

- i. Foley's catheter shall be inserted in the operation theatre after the patient has been anaesthetised.
- j. Refer Standard Operating Procedures of Maternity Operation Theatre.
- k. Time for decision to caesarean section is less than 30 minutes.

Measurable elements of 9.2.3

- 1. Continuity and coordination shall be evident throughout all phases of patient care.
- 2. Continuity and coordination are evident to the patient.

All surgery will be decided at specialist level (Std: 100%)

9.2.4 Standard

Available policy / procedures guide for Red Alert.

Intent 9.2.4

The policy is to guide the staff to deal with patients in emergency situations. This will appropriately and effectively reduce the related risk as various level of care are involved as well as consultants/specialist from other departments (etc Anaesthesia) Refer: Obstetric RED ALERT.

Measurable elements 9.2.4

- 1. Assessment of the care of emergency patients are followed by appropriate policies and procedures.
- 2. Patients receive care consistent with the policy and procedures.
- 3. Time from initiation till team present to attend to patient.

Utilisation of obstetric red alert in identified emergencies (Std: 100%)

9.3 MEDICATION MANAGEMENT USE

Refer Operational Policies for Medication Management Use.

9.4 REFERRAL

9.4.1 Standard

The department shall cooperate with health care practitioners/ other departments and outside agencies to ensure timely and appropriate referral.

Intent of 9.4.1

1. A referral shall be made appropriately to other department or for outside agencies if necessary.
2. Interdepartmental referral shall be decided at the specialist / consultant level.
3. All interdepartmental referral shall have an input from the specialist / consultant.
4. A referral letter, containing the summary of the patient's problem and care shall be given to patient for the next practitioner.
5. Transport arrangement shall be made for transfer to other department / hospital.

Measurable elements of 9.4.1

1. Patient shall be appropriately referred.
2. Referral shall be made appropriately when necessary.

3. Urgent referral should be seen within 1 hour.

Referrals should be at specialist level (Std: 100%)

9.5 DISCHARGE / TRANSFER FROM LABOR ROOM / SUITE

9.5.1 Standard

Intradepartmental transfers are handled by staff nurse in labour room.

Intent of 9.5.1

1. Staff nurses call the HDW / wards to see the availability of beds, if present the patient and babies tag numbers are informed prior to sending the patient.
2. Staffs from labour room are responsible for transfer of postnatal mothers and their babies to ward or High Dependency Ward (HDW).
3. On receiving the mother and baby, the ward staff shall check their tags to verify their identification – ‘Correct baby to the correct mother’. Ward staff shall go through the checklist – ‘Penilaian Postnatal’.
4. Ensure babies’ safety:

Refer ‘Pekeliling Ketua Pengarah Kesihatan Bil 1 / 2007 : Garispanduan Sistem Kawalan Keselamatan Bayi di Hospital-Hospital Kementerian Kesihatan Malaysia’ (Guidelines on Safety of Babies in Ministry of Health Hospitals)

Measurable elements of 9.5.1

1. Call made prior to sending of patient.
2. Names of patient informed.

3. Check done on admission prior to sending the patients to the ward.

9.5.2 Standard

Interdepartmental / other hospital transfer requested based on severity of illness or decided by the Specialist.

Intent of 9.5.2

1. Labour suite staffs are responsible to transfer the babies that need to be admitted to Maternity Neonatal Intensive Care Unit (MNICU) after the Paediatric medical officer had discussed with the specialist and the approval obtained and documented.
2. Transfer of patient to other departments need to follow the hospital policy.
 - a. Refer Guidelines on referrals to other departments: Pindah Keluar ke Wad Lain Dalam Hospital.
3. Transport arrangement shall be made for transfer to other department / hospital
 - a. Refer Format for request for transport : Permohonan Perkhidmatan Kenderaan

Measurable elements of 9.5.2

1. Continuity and coordination shall be evident throughout all phases of patient care.
2. Continuity and coordination are evident to the patient.
3. Patient safety is ensured and acknowledge

Compliance to practice protocols (Std: 100%)

9.6 DEATH

Refer Operational Policies for Obstetric Wards.

10.0 HIGH DEPENDENCY WARD (HDW)

Standards

10.1 Criteria for admission

- 10.1.1 Admission to a unit providing intensive or specialized services is determined by established criteria.

10.2. Admission procedure

- 10.2.1 Process of patient's assessment and admission.
- 10.2.2 Patient with emergency or immediate needs is given priority for assessment and treatment.
- 10.2.3 Patients and families receive information on the proposed care, the expected outcome of the care and any expected cost for the care.

10.3. Care of patient in HDW

- 10.3.1 A qualified individual is identified as responsible for the patient's care.
- 10.3.2 The department provides continuity of patient care services and coordinates it among health professionals

10.4. Care delivery for patient in HDW

- 10.4.1 Policies and procedures and applicable laws and regulations guide the uniform care of all patients.
- 10.4.2 Available process to integrate and coordinate the care provided to each patient.

- 10.4.3 The care of patients shall be planned and written in patient's record.
- 10.4.4 Procedures performed shall be written into the patient's record.
- 10.4.5 Patients and families are informed about the outcome of care and treatment including unanticipated outcomes.
- 10.5 Medication management and use
- 10.6. Food and nutrition therapy
- 10.7. Pain management and end of life
- 10.8. Referral
- 10.9. Discharge and transfer
 - 10.9.1 Discharge procedure from HDW to obstetric ward.
 - 10.9.2 Discharge / transfer of patient from HDW to other department.
- 10.10 Death

10.1 CRITERIA FOR ADMISSION

10.1.1 Standard

Admission to a unit providing intensive or specialized services is determined by established criteria.

Intent of 10.1.1

1. All admissions to HDW require consultation with consultant / specialist.

2. Indications of admissions include :
- i. Antenatal medical / obstetric complications
 - Cardiopulmonary disorders
 - Decompensated or complicated heart disease
 - Acute bronchial asthma
 - Severe lung disease
 - Severe hypertension / impending eclampsia / severe pre eclampsia
 - Obstetric haemorrhage
 - Other severe medical / surgical conditions & their complications
 - ii. Post partum complications
 - As above
 - Post partum haemorrhage
 - Sepsis
 - Deep vein thrombosis / pulmonary embolism
 - iii. Post-operative patients
 - Complicated caesarean section / instrumental deliveries
 - Caesarean hysterectomy
 - Severe genital tract trauma
 - Complicated gynaecological surgery
 - iv. Obstetric or gynaecological patients transferred in from Intensive Care Unit (ICU) or HDW from other departments.
 - v. Other cases deemed appropriate by consultant / specialist.

Measurable elements of 10.1.1

1. The department has an established entry criteria for its intensive services.
2. The patients transferred or admitted to HDW meet the criteria and this shall be documented in the patient's record.
3. Patients who no longer meet the criteria to remain in HDW shall be transferred out.

Compliance to admission criteria (Std: 100%)

10.2 ADMISSION PROCEDURE**10.2.1 Standard**

Process of patient's assessment and admission.

Intent of 10.2.1

1. Decision on admissions need to be made by consultant / specialist.
2. Admission can be from Patient Admission Centre (PAC), obstetric / gynaecological wards, labour suite, Intensive Care Unit, or other departments and hospitals.
3. Detailed and clear written instruction on the immediate and short term management of the patient must be available. These instructions must be written by the medical officer / specialist.
4. Specialist / medical officer in charge to be informed regarding patient's admission and requirement.

5. Staff nurse in charge of ward to be informed regarding patient's admission and requirement.
6. Preparation of bed.
7. Transfer in of patient to HDW : accompanied by the staff nurse and house officer / medical officer.
8. Receiving of patient;
 - a. Patient's condition and vital signs noted.
 - b. Fetal heart rate shall be checked if antenatal patient.
 - c. Uterine size, amount of bleeding per vaginum noted if postpartum patient.
 - d. Ensure that intravenous lines, catheters, drainage tubes etc, are functioning.
 - e. Ensure that management instructions are clear and complete. To clarify if otherwise.
 - f. Update records on drug therapy, observations, investigations, intravenous fluids regime, blood transfusion, etc.
9. Admission book.
 - a. Details of the patient to be entered into the HDW admission book
10. Patients shall use hospital attire.
11. Rooming-in is encouraged in line with the Baby Friendly Hospital concept.
12. Two relatives shall be allowed to visit at anytime provided no nursing procedures / ward rounds are being done at that time.

Measurable elements 10.2.1

1. The staff shall be familiar with the policies and procedures and follow them.

Compliance to practice protocols (Std: 100%)

10.2.2 Standard

Patient with emergency or immediate needs are given priority for assessment and treatment.

Intent of 10.2.2

1. Medical officers to review patient within 30 minutes of admission to HDW or immediately depending on case to case basis.
2. Patient with immediate needs shall be reviewed by specialist immediately.

Measurable elements of 10.2.2

1. Patients are prioritized based on the urgency of their needs.

All patients to be reviewed by medical officer within 30 minutes of admission (Std: 100%)

10.2.3 Standard

Patients and families receive information on the proposed care, the expected outcome of the care and any expected cost for the care.

Intent of 10.2.3

1. The medical officer / specialist shall counsel the patients and families on the proposed care, expected outcome and expected cost, if any.
2. The information given shall be sufficient for the patients and families to make a knowledgeable decision.

3. The information given shall be documented properly in the patient's record and signed by medical officer, specialist or consultant.

Measurable elements of 10.2.3

1. Patient and family receive sufficient information to make a knowledgeable decision.

Compliance to practice standards (Std: 100%)**10.3 CARE OF PATIENT IN HIGH DEPENDENCY WARD****10.3.1 Standard**

A qualified individual is identified as responsible for the patient's care.

Intent of 10.3.1

In order to maintain continuity of care, throughout the patient's stay in the hospital, the individual with overall responsibility for the patient's care or particular phase of patient's care is clearly identified.

1. All new admission to HDW shall be assessed and document in patient's record by house officer / medical officer immediately.
2. All patients admitted should be seen by the respective specialist at least twice during day time. On call specialist shall review the patient's during on call periods and review all new admissions.
3. House officer / medical officer shall do HDW rounds at least three times day and review patients as whenever necessary.
4. Sister in charge shall ensure a smooth running of HDW, high standard of nursing care and supervise the staff activities.

5. If the responsible person is on leave or away, the on-call person shall take over the responsibilities of that person. If the on-call person is away, then the following day on-call person shall take over the responsibilities.

Measurable elements of 10.3.1

1. The house officer / medical officer / specialist / consultant / sister responsible for the patient's care is identified.
2. The individual is identified to the department's staff by the department's roster and writing their names on the white board in the HDW.

Compliance to practice standards (Std: 100%)

10.3.2 Standard

The department provides continuity of patient care services and coordinates it among health professionals.

Intent of 10.3.2

Several departments and services may be involved in providing care. The department shall implement continuity and coordination of care among physicians, nurses and other health care providers.

1. Interdepartmental referral shall be decided at the specialist / consultant level.
2. All interdepartmental referral shall have an input from the specialist / consultant.
3. Interdepartmental transfer shall be decided by the specialist.
4. The HDW ward staffs are responsible on the patient's transfer to labour suite or Maternity Operation Theatre (MOT) or other departments.

5. The staff shall communicate for coordination of care at intra or interdepartmental level.

Measurable elements of 10.3.2

1. Available coordination of patient care in the department or at the inter-departmental level.

All referrals will be at specialist level (Std: 100%)

10.4 CARE DELIVERY FOR PATIENT IN HIGH DEPENDENCY WARD (HDW)**10.4.1 Standard**

Policies and procedures and applicable laws and regulations guide the uniform care of all patients.

Intent of 10.4.1

1. Patient with health problems and care needs have a right to receive the same quality of care throughout the organization.
2. Uniform patient care is reflected in the following :
 - i. Access to an appropriate care and treatment do not depend on the patient's ability to pay or the source of payment.
 - ii. Access to appropriate care and treatment by qualified practitioner does not depend on the day of the week or time of the day.
 - iii. Acuity of the patient's condition determines the resources allocated to meet the patient's need.

- iv. The level of care provided to patients is the same throughout the organization.
- v. Patients with the same nursing care needs receive comparable levels of nursing care throughout the organization.

Measurable elements 10.4.1

- 1. The organization's leaders collaborate to provide uniform care process.
- 2. Policies and procedures guide uniform care.

Access to place or type of care will be based on clinical need (Std: 100%)

10.4.2 Standard

Available process to integrate and coordinate the care provided to each patient.

Intent of 10.4.2

- 1. The integration and coordination of patient care activities are goals that result in efficient outcomes.
- 2. The patient's record facilitates and reflects the integration and coordination of care.

Measurable elements of 10.4.2

- 1. Care planning and delivery is integrated and coordinated among settings, departments and services.
- 2. The results or conclusion of any patient care team meetings or discussions are written in the patient's record.

Documentation of any multidisciplinary including family discussion (Std 100%)

10.4.3 Standard

The care of patients shall be planned and written in patient's record.

Intent of 10.4.3

1. Each review should include complaints, findings, results, assessment, diagnosis / working diagnosis and plan of management. In booked cases such as elective and planned admission, this plan should be stated clearly in the notes.
2. Every patient who is admitted to the HDW from the ward must have a written plan of management.
3. All entry in the case notes must include:
 - a. Date (include the year)
 - b. Time (use the 24 hour clock)
 - c. Signature and name clearly printed or stamped
4. Self- inking rubber stamp is recommended (Compulsory for all house officers). with MMC number enclosed.
5. When notes are written on behalf of others, the names of the senior doctor should head the entry;
S/B : SEEN BY
D/W: DISCUSSED WITH
S/W: SEEN WITH

Measurable elements 10.4.3

1. The care planned for each patient is written in the patient's record by the health professional providing the care.
2. The plan is updated or revised, as appropriate, based on the assessment of the patient by the care providers.
3. The care providers signature and stamp must be present.

Compliance to practice standards (Std: 100%)

10.4.4 Standard

Procedures performed shall be written into the patient's record.

Intent of 10.4.4

Diagnostic and other procedures performed and the results shall be written in the patient's record.

Measurable elements of 10.4.4

1. Procedures performed are written into the patient's record.
2. The results of procedures performed are written into the patient's record.

Compliance to practice standards (Std: 100%)

10.4.5 Standard

Patients and families are informed about the outcome of care and treatment including unanticipated outcomes.

Intent of 10.4.5

The health professional shall inform the patient and their families about the outcome of care and treatment including the unanticipated outcomes as well as document their discussions.

Measurable elements of 10.4.5

1. Patient and families are informed about the outcome of their care and treatment
2. Patient and families are informed about any unanticipated outcome of their care and treatment.
3. Information that is discussed are documented and signed.

Compliance to practice standards (Std: 100%)

10.5 MEDICATION MANAGEMENT AND USE

Refer to chapter on medication and management use.

10.6 FOOD AND NUTRITION THERAPY

Refer to chapter on food and nutrition therapy.

10.7 PAIN MANAGEMENT AND END OF LIFE CARE

Refer to chapter on pain management and end of life

10.8 REFERRAL

Refer Operational Policies, Obstetric wards

10.9 DISCHARGE AND TRANSFER

10.9.1 Standard

Discharge procedure from HDW to obstetric ward.

Intent of 10.9.1

1. Consultant / specialist shall decide on discharge from HDW.
2. To inform the respective specialist / medical officer and staff nurse in charge of the ward about transfer of patient.
3. Proper plan of management and summary to be documented in the HDW discharge summary form.
4. Ensure all treatment are up to date prior to discharge.
5. Passing over care of patient shall be done when the staff from ward taking the patient to their ward.
6. Patient to be accompanied by staff nurse from the ward where patient is to be transferred.

Measurable elements 10.9.1

1. Respective doctors decide on the patient's transfer and all other respective doctors and staff are aware of the patient movement.
2. Continuation of care in management and treatment are ensured by following intent of 10.9.1 no 3, 4 and 5.
3. Patient is to be transferred with staff to ensure safety.

Compliance to practice standards (Std: 100%)

10.9.2 Standard

Discharge / transfer of patient from HDW to other department.

Intent of 10.9.2

1. Consultant / specialist shall decide transfer from HDW to other department after discussion with the appropriate specialist / consultant.
2. To inform the respective specialist / medical officer and staff nurse in charge of the ward about transfer of patient.
3. Proper plan of management and summary to be documented in the HDW discharge summary form.
4. Ensure all treatment are up to date prior to discharge
5. Patient to be accompanied by staff nurse / medical officer to where patient is to be transferred. Ventilated patient will be accompanied by staff from Intensive Care Unit (ICU).
6. Transport / ambulance shall be made available prior to mobilization of patient.

Measurable elements 10.9.2

1. Respective doctors decide on the patient's transfer and all other respective doctors and staff are aware of the patient movement.
2. Continuation of care in management and treatment are ensured by following intent of 10.9.2 no 3, 4 and 5.
3. Patient is to be transferred with appropriate staff to ensure safety.

Compliance to practice standards (Std: 100%)

10.10 DEATH

Refer to Standard Operating Procedure (SOP), Obstetric wards.

11.0 MATERNITY OPERATION THEATRE

Standards

- 11.1 Patients are planned for elective and emergency caesarean section at maternity operation theatre.

Intent of 11.1

1. Elective cases are planned earlier and performed from pre-determined hours (Monday to Friday, 8am-5pm).
2. All cases listed for operation are by a specialist.
3. The patients are counselled regarding the indication, procedure and associated complications prior to the surgery and they are admitted one day prior to the day of operation.
4. The patients together with the husband are reviewed again by the obstetrician and gynaecologist who is planned to perform the operation.
5. Necessary investigations are taken and reviewed prior to the operation.
6. All patients are reviewed by the anaesthetist one day prior to the operation and are counselled again regarding the operation and type of anaesthesia planned.
7. All high risk cases are performed by specialist/consultant.
8. Once the patient has been counselled, a written consent is taken from the patient.

9. Blood is group and cross matched for all high risk cases according to the hospital protocols. Other patients shall have blood grouped and saved as appropriate.
10. A day prior to surgery a list is drawn up of all the cases and the Maternity Operation theatre list is signed by the Head of Department.
11. The staff from the respective wards/units shall notify the staff of the Maternity Operation Theatre (OT) by means of an OT dispatch book prior to the surgery.
12. The respective wards shall be responsible for transporting the patients to and from the Maternity OT after being informed by the OT staff.
13. The Operation Theatre guidelines for patient's attire shall be adhered to.
14. At the Operation Theatre "transfer bay" the ward staff shall "hand over" the patient to the theatre nurse to ensure patient's safety. Any special instructions shall be conveyed to the OT nurse.
15. The Operation Theatre staff shall carry out the necessary checklist in accordance to the standard procedures.
16. The ward staff shall be informed of any cancellation of cases.
17. All OT staff and relatives accompanying patients shall abide by the rules' and regulations pertaining to the OT attire.
18. Mentally handicapped and psychiatric patients may be accompanied into the OT by a single relative who signed the operation consent.

19. No food and drinks are allowed in the OT except in the designated rest rooms.
20. The OT shall receive all their sterile supplies from CSSD.
21. All linen and instruments shall be packed in OT before being sent to CSSD for sterilization.
22. Short cycle sterilization for dropped instruments shall be carried out in the OT
23. The Operation Theatre shall be cleaned following OT set guidelines and procedures.
24. The Operation Theatre shall be closed for routine cleaning for a few hours once a week
25. Existing regulations on cleaning, sterilization and disinfection as stated in the “Guidelines on control of Hospital Acquired Infections and the Disinfections and Sterilization Policy and Practice”, MOH, 1997 (Revised) shall be observed.
26. For infectious cases, the appropriate guidelines issued by the MOH will be adhered to.
27. The sterility tests for air and equipment in OT and the bacteria surveillance tests shall be carried out as and when indicated.

Measurable elements of 11.1

1. Cases reviewed by medical officer/registrar.
2. Cases reviewed by specialist
3. Cases reviewed by anaesthetist
4. Counselling of patients and relatives
5. Consent taken from patient
6. Blood investigations taken and reviewed by doctor
7. OT checklist
8. Sterile supplies from CSSD
9. Air sterility and bacteria sterility test in OT
10. Cleaning roster for OT
11. OT list prepared and signed by Head Of Department

The standard for all the above measurable elements shall be 100%

12.0 GYNAECOLOGY WARDS

Standards

12.1 Admission to gynaecological ward should be in the appropriate manner following the various guidelines.

Intent of 12.1

1. Admission to the gynae ward is through A&E unit, OPD or Gynae clinic. Referrals from other hospitals will be admitted through A&E. Patients from other wards will be transferred directly to the gynae ward.
2. All unstable patients at A&E unit will be resuscitated and stabilized before being either sent to GOT, GICU or to the gynae ward accompanied by the doctor and staff nurse.
3. All patients admitted to the ward will be seen by a staff nurse within 10 minutes and vital signs recorded and bed allocated.
4. All new cases will be seen by the doctor within 20 minutes from admission.
5. All new cases will be seen and managed or discussed with a specialist or consultant.
6. A planned admission would be admitted by specialist with the management documented.
7. The complete plan of management will be documented in the folder.
8. The diagnosis, current condition and plan of treatment will be explained to the patient and relatives once again by the medical officer in charge of ward.

9. The patient would be managed with the help of a multidisciplinary team if needed with the appropriate subspecialty referral given.
10. The patients would be discharged with a discharge note to be kept with the patient including details of medication, treatment and new appointment dates, copy of which will be in the notes.
11. The BHT of the patients will be dispatched to the record office within 72 hours of discharge.
12. The decision to discharge is only made by a specialist.
13. In cases of emergency surgical procedures, it would be done within 6 hours from the time of admission.
14. In cases of elective surgical procedures, it would be done within 3 months from the date of diagnosis, except for oncology cases.
15. All medications, including benefits and side effects would be explained to the patient.

Measurable elements of 12.1

1. Time taken from admission until review by doctor < 20 minutes
2. All cases to be seen and managed by specialist at least once during admission daily
3. Discharge summary of patients to be completed within 72 hours
4. Elective cases admitted should have a plan of management written.

The standard for all the above measurable elements shall be 100%

13.0 GYNAECOLOGY OPERATION THEATRE

Standards

13.1 Cases posted for elective gynaecology operation theatre.

Intent of 13.1

1. All cases are seen by a medical officer or specialist in the gynaecology clinic and decision for operation is made by specialist.
2. A temporary date is given after discussion with patient and entered in the OT book based on the appropriate subspecialty.
3. Operation list is made after the patients are fully investigated. (example CT scan)
4. Weekly pre-op discussions are held and the cases are discussed in detail. They are either planned to be reviewed, re-examined or an operation date is confirmed or pre or post posted according to priority.
5. Patients are informed to come for review and for those who are planned for operation; an admission form is given to them. Anaesthetic assessment forms are also given to all high risk cases prior to being discussed and put on the OT list.
6. The waiting time for elective cases from time of diagnosis to operation is less than 6 months.
7. All operations are performed by specialists or OT supervised by specialist.
8. The patient is counselled regarding the indication, the procedure and complications by the specialist.

9. The relatives are also informed and updated regarding the nature and complications of the procedure.
10. Informed written consent is taken from the patient prior to surgery.
11. All cases are seen by anaesthetist prior to surgery.
12. All investigations are taken and reviewed by the attending doctor and if necessary, blood is grouped and cross matched.
13. Selected complicated patients will be required to undergo bowel preparation.
14. Pre operative assessment is done by the operating surgeon prior to the operation.

Measurable elements of 13.1

1. Waiting time from diagnosis to operation.
2. Preoperative decision made by specialist.
3. Written high risk consent from patients.
4. Number of high risk cases seen by anaesthetist.
5. Number of cases cancelled by anaesthetist.
6. Operative complications, ureteric, bladder and bowel injury and unplanned return of patient to operation theatre- incident report

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

14.0 GYNAECOLOGY DAY CARE PROCEDURES

Standard

14.1 Day care hysteroscopy

14.1.1 Patients undergoing hysteroscopy procedures must fully satisfy all requirements and is decided by specialist.

14.2 Day Care Tubal Ligations

14.2.1 Patients undergoing laparoscopic Tubal Ligations must fully satisfy all requirements and is decided by specialist.

14.1 DAY CARE HYSTEROSCOPY

14.1.1 Standard

Patients undergoing hysteroscopy procedures must fully satisfy all requirements and is decided by specialist.

Intent of 14.1.1

1. All patients are seen at the Gynae Clinic by Specialists / Medical Officers.
2. Only specialists can order for a hysteroscopy after explaining to the patient regarding the procedure.
3. The Clinic Nurse will inform the Day Care Nurse regarding the case and an appointment is given within 3 to 4 weeks.
4. On appointment day , patient arrives half an hour prior to the procedure and the vital signs are taken.
5. The doctor will review the patient and the procedure will be re-explained and consent taken.

6. After the procedure and if a specimen is sent for histopathology, the patient will be re-counselled regarding the findings any complications and discharged once well. The review clinic appointment is given within 2 weeks in urgent cases or 6 weeks for normal cases.

Measurable elements of 14.1.1

1. Time taken from consultation to time procedure being done.
2. All cases should be managed by specialist or privileged medical officer.
3. Waiting time at hysteroscopy clinic
4. Time taken for HPE report to be ready.

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

14.2 DAY CARE TUBAL LIGATIONS

14.2.1 Standard

Patients undergoing laparoscopic Tubal Ligations must fully satisfy all requirements and is decided by specialist.

Intent of 14.2.1

1. All patients for tubal ligation are seen at the gynaecology clinic.
2. They are given an appointment during the first 2 weeks of their LMP.
3. On the morning of the procedure, a UPT and an Ultrasound scan is done for the patient.

4. Patient is explained regarding the procedure failure rates and risks before consent is taken.
5. After the procedure, patient is told to rest and discharged after 6 hours with adequate analgesics.
6. Patients are followed up 2 weeks post laparoscopic BTL.

Measurable elements of 14.2.1

1. Time taken from appointment to procedure.
2. Only credentialed and privileged doctors should do the case.
3. Ensure consent with proper counselling done

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

15.0 GYNAECOLOGY SATELLITE SERVICES

15.1 Standard

Satellite services provided by O & G Departments.

Intent of 15.1

1. The O&G specialists from the Fetomaternal, Reproductive Medicine, Gynaecology and Uro-gynaecology units are providing specialist care at other hospitals.
2. The days for these services are preplanned and known to the visiting hospitals.
3. The specialists will usually do procedures in the morning and see patients in the afternoon session.
4. They will also bring patients to other hospitals to be operated on.
5. Patient seen by visiting Reproductive Medicine Specialist would continue the care for patients who require ART at the Kuala Lumpur Hospital.

Measurable elements of 15.1

1. Specialists in other hospitals trained by subspecialists.
2. Shorter waiting time for major surgery

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

16.0 SPECIALIST CLINICS

Standards

Obstetrics and gynaecology clinic

- a. Patients with appointment
- b. Walk in patients
- c. General clinic policies

16.1 Standard

Patients with appointment

Intent of 16.1

1. A planned maximum number of patients will be seen per day for every clinic session.
2. All patients referred to the clinic are expected to present with a referral letter.
3. The appointment will be fixed according to the staggering system in the first come first serve basis.
4. Patient with more urgent clinical conditions will be given an earlier appointment.
5. All appointments will be given not later than 6 weeks.
6. The hospital has the authority to change the appointment to a different date and patient will be informed of the changes.
7. Patients are expected to be punctual according to the appointment time given.

8. The time mentioned is according to clock at the clinic counter.
9. All patients arriving earlier than the appointment time will be registered only at the appointment time given.
10. All patients are under the shared care system. There will be a joint management between this clinic and the referring doctor.
11. The hospital will have the authority to discontinue follow up or discharge the patient once the patient is fit to be treated in their own clinic again.
12. Patients who are unable to attend a scheduled appointment should inform the hospital. The reappointment can be made via telephone call or in person.
13. Any patient who default appointments will be traced via the hospital default tracing system. A reappointment will be given.
14. Appointments for patients discharged from the ward have to be fixed via the clinic.

Measurable elements of 16.1

1. Total patients seen in clinic
2. Waiting time in clinic to see doctor (< 30 minutes)
3. New appointments within 6 weeks
4. Defaulter tracing and giving new appointments
5. Number of cases seen by specialist/consultant per clinic session

6. Time of completion of clinic sessions

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

16.2 Standard

Walk in patients

Intent of 16.2

1. Walk in patient who request for immediate medical attention are to be discouraged.
2. The urgency of medical attention will be decided by the clinic medical officer or specialist. If the presenting complaint is deemed to be urgent, patients will be seen immediately. Otherwise an appointment will be given accordingly.
3. Any patient in labour seen in the clinic will be clerked and admitted directly to the ward and the investigations will be taken and labelled in the ward.
4. Inpatients from other departments should be referred to the on-call team after 1700hrs.
5. Outpatients from any department who need urgent attention should be discussed with the specialist/consultant of the clinic and decisions are made if it should be referred to the on-call team.

Measurable elements of 16.2

1. Number of walk in patients seen in clinic
2. New appointment given within 6 weeks

3. Appropriate assessment of urgent referrals.

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

16.3 Standard

General clinic policies

Intent of 16.1.3

1. Patients shall be charged according to the Fees (Medical) Order, 1982 and other regulations in force.
2. All relevant patient records shall be made available before the start of clinic sessions.
3. Patients' records shall be kept confidential.
4. The specialist clinic shall provide services for referred cases and cases on specialist follow-up.
5. The specialist should see the high risk and complicated cases.
6. All cases seen by the house officer should be jointly seen with the medical officer or specialist.
7. The gestational diabetic clinic will be conducted by the maternal-fetal team with the help of the clinic group of doctors.
8. The gynaecology clinics will be conducted with the help of specialists from reproductive medicine unit, gynaecology unit and urogynaecology unit in rotation. Two specialists from these units will be conducting the gynaecology clinic.

9. The doctors shall be assisted and chaperoned by trained dedicated staff who may be a sister, staff nurse, jururawat masyarakat (assistant nurse) or midwives.
10. All cases admitted to the ward should have a plan of management clearly stated in the case notes. It is mandatory to inform the ward doctors of the complicated case admitted via clinic.
11. Injections and minor procedures shall be carried out in the specified room.
12. The Clinic shall maintain the Clinic statistics and submit to the Medical Records Office monthly.
13. All nurses working in the clinic are expected to be friendly, courteous and helpful to patients and attired according to MOH policy.
14. Queries by patients have to be attended to immediately.
15. Any patient's dissatisfaction should be handled in a very sensitive manner and clinic sister should be involved. The clinic sister will decide whether an incident report is necessary in each case.
16. The clinic consultant and the clinic coordinator should be informed. The Clinic shall maintain a record and notify the Matron, the Head of Department and the Hospital Director of any untoward incident in the clinic.
17. All relevant Guidelines and Protocols from MOH shall be in practiced in the clinic.
18. At the end of the day, the clinic doors shall be locked and the key returned to the Admission Room by a designated staff member.

17.0 EARLY PREGNANCY ASSESSMENT UNIT (E.P.A.U)

Standards

- 17.1 All patients will receive assessment and care based on their identified health care needs and the organization's mission and resources
- 17.2 A systematic registration process is in place.
- 17.3 Investigations / confirm the diagnosis.
- 17.4 A systematic admission process is in place.
- 17.5 Procedures are performed when necessary by qualified trained staff.
- 17.6 Discharge and Follow Up care

17.1 Standard

All patients will receive assessment and care based on their identified health care needs and the organization's mission and resources.

Intent of 17.1

1. All patients came to EPAU will be seen and assessed regardless of the sources of the referral, including self referral.
2. The initial assessment will be done by dedicated staff nurses followed by assessment by medical officer and house officer. (In the event of an emergency the appropriate help will be summoned immediately)
3. All cases will be seen and reassessed by medical officer who will then decide on further management.

4. All cases will be seen and reviewed by medical officer within specific agreed time (30 minutes for non-emergency cases).
5. Specialist or consultant will be available at all time in case medical officer need advice or help.
6. Guidelines for patient's care will be made available for reference. The guidelines must be up to date and must be reviewed from time to time to be concordant with current accepted practice.

Measurable elements of 17.1

1. The department will accept all cases referred from the primary / secondary source including 'walk in' cases for further assessment and management.
2. The department will provide competent staff to deal to with patient's problem.
3. The department will provide adequate and appropriate facilities to deal with patient's problem within available and affordable resources.
4. The department will make sure the care is in line with current accepted practice.
5. Based on initial assessment the department will facilitate further care in term of in-patient treatment or out-patient follow-up.

Compliance to practice standards (Std: 100%)

17.2 Standard

A systematic registration process is in place.

Intent of 17.2

1. Patient's record shall be prepared for documentation of patient's assessment and relevant investigations done.
2. All relevant patients' records shall be made available before the start of clinic sessions for follow up cases.
3. BP and PR shall be checked and brief assessment shall be done
4. All patients will be attended by the dedicated staff at EPAU.
5. Patient's name and particulars shall be registered in EPAU's registration book.
6. Patients shall be charged according to the Fees (Medical) Order, 1982 and other regulations in force.

Measurable elements of 17.2

1. Availability of specific activities for registration in EPAU.

Compliance to practice standards (Std: 100%)

17.3 Standard

Investigations / confirm the diagnosis.

Intent of 17.3

1. Blood tests, urine tests etc specimens are taken by trained staff and sent to the relevant laboratories.

2. All the necessary facilities such as an ultrasound machine, physical examination set, resuscitation set and required laboratory facilities will be made available at all time.
3. All investigation results will be traced prior to the patient's appointment for follow up patient.

Measurable elements of 17.3

1. Necessary investigation are performed as required
2. All investigation results are reviewed and written in the patient's notes.

Compliance to practice standards (Std: 100%)

17.4 Standard

A systematic admission process is in place.

Intent of 17.4

1. Patients who require admission shall be admitted via the Patient Assessment Centre.
2. All patients for admission need to have admission form (Borang Arahan Kemasukan Wad – JRP 3/94(Pin. 1/06) and to be registered at the admission registration counter.
3. If the patient is acutely unwell, registration in the PAC will be carried out by the clinic staff and she will be transported directly to HDW or one of the general wards.

Measurable elements of 17.4

1. Admission forms are filled out by a doctor.
2. The dedicated staffs will facilitate admission processes for patients who require in-patient treatment.
3. The admission processes will comply with the agreed admission procedures.

Compliance to practice standards (Std: 100%)

17.5 Standard

Procedures are performed when necessary by qualified trained staff.

Intent of 17.5

1. Informed consent is obtained from the patient regarding risks and benefits of a procedure (eg. Evacuation of retained POC).
2. Procedures are performed by Medical officer or specialist in problematic cases.
3. Procedures are performed in Maternity Operation Theatre.
4. Possible complications and follow up plan is explained to the patient and documented in the notes.

Measurable elements of 17.5

1. Consent form is read and signed by patient in the presence of a witness.
2. Documentation of procedure being performed is kept in patients' notes.

Compliance to practice standards (Std: 100%)

17.6 Standard

Discharge and Follow up care

Intent of 17.6

1. Blood group and rhesus shall be identified for all patients prior to discharge.
2. A summary of their care will be documented in the patient's antenatal card the discharge summary (a copy shall be given to the patient)
3. A written follow up plan and appropriate appointment shall be given.
4. For outpatient's follow up care :
 - a. The dedicated staff will also provide an adequate advice and counselling based on patient problem and needs.
 - b. The staff will also be available to give advices if patients contact by phone, (EPAU phone number will be given to all patient before they leave).
5. For inpatient and outpatient who have never been seen in the health clinic, advice will be given to be booked to the closest clinic to their home.
6. A referral letter will be given to the patient if the patient is being discharged to other centre.
7. Patients shall be charged according to the Fees (Medical) Order, 1982 and other regulations in force.

Measurable elements of 17.6

1. Documentation of patients care is written in her antenatal book / discharge summary.

2. Appropriate plan and advice is given on discharge to outpatient or inpatient care.
3. Advice and counselling should be documented.

Compliance to practice standards (Std: 100%)

Subspecialties

18.0 MATERNAL FETAL MEDICINE UNIT

Introduction

The subspecialty field of Maternal Fetal Medicine (MFM) generally covers the care and management of the high risk obstetric patient and also the screening, diagnosis and management of the sick or abnormal fetus. The areas of responsibilities of a Maternal Fetal Medicine service include:

1. Maternity wards (Antenatal & Postnatal Ward)
2. Labour wards & maternity operation theatre
3. Obstetric daycare clinic
4. Prenatal diagnostic and therapeutic centre
5. Combined obstetric & medical clinic

Standards

- 18.1 Patients shall be seen in the Clinic on an appointment basis.
- 18.2 A systematic registration process is in place.
- 18.3 All patients receive specialist care and treatment.
- 18.4 Procedures are performed when necessary by qualified trained staff.
- 18.5 Referrals and liaison with other departments when more specialized care is required.
- 18.6 Results of investigations aid/confirm the diagnosis.
- 18.7 A systematic admission process is in place.
- 18.8 After full assessment, patients not requiring further MFM care are discharged.
- 18.9 High risk pregnancies patients receive MFM specialist care.
- 18.10 The MFM unit is involved in training and education.
- 18.11 The MFM unit participates in research.
- 18.12 All administrative and clinical services in the MFM unit run efficiently
- 18.13 Criteria and timing of referrals

18.1 Standard

Patients shall be seen in the Clinic on an appointment basis.

Intent of 18.1

1. Appointments are available on predetermined days.
2. Referrals must be discussed with a MFM specialist before an appointment is given.
3. Referred 'walk-in' patients need to be discussed with MFM specialist as to whether they are seen on the same day or whether an appointment is given for a later date.
4. If there is no available MFM specialist to accept referral, details of referring doctor is left with clinic staff and MFM specialist will return call as soon as possible.

Measurable elements of 18.1

1. Patients are only accepted if they are referred to MFM specialist.
2. Patients referred from anywhere other than the O&G department must have a referral letter.
3. Patients' details are recorded and an appointment is booked.

Compliance to practice standards (Std: 100%)

18.2 Standard

A systematic registration process is in place.

Intent of 18.2

1. All relevant patients' records shall be made available before the start of clinic sessions.
2. All patients will be attended to at registration by a member of staff within 30 minutes of arrival.
3. BP and weight will be checked for all patients. Urinalysis will be performed for all patients with hypertension.
4. Patients will be seen according to appointment time and registration number.
5. Patients shall be charged according to the Fees (Medical) Order, 1982 and other regulations in force.

Measurable elements of 18.2

1. Documentation of patients BP, weight and urinalysis (if indicated) in the notes and antenatal book.
2. All patients have a waiting number and are seen according to number.

Compliance to practice standards (Std: 100%)

18.3 Standard

All patients receive specialist care and treatment.

Intent of 18.3

1. Patients are seen by a MFM specialist or consultant or by a medical officer under close supervision by the MFM specialist or consultant.

2. History taking, physical examination and ultrasound examination is performed.
3. Ultrasound findings are shown and explained to the patient as the scan is being
4. Counselling is performed in a private room by MFM specialist in the presence of a nurse to provide support to the patient.
5. Implications of any fetal abnormality are explained.
6. If prenatal diagnosis is necessary, counselling regarding the options of prenatal diagnosis (amniocentesis, chorionic villus sampling or fetal blood sampling) and their individual risks and advantages is performed.
7. The length of time to obtain results of prenatal diagnosis is informed to the patient.
8. If the patient is agreeable for prenatal diagnosis, a suitable appointment is arranged for the procedure.
9. A cardiotocography may be performed to assess fetal well being. The cardiotocograph is interpreted by a medical officer, MFM specialist or consultant.

Measurable elements of 18.3

1. All patients are managed by a MFM specialist or consultant.
2. Documentation of relevant examination findings in the notes as well as antenatal book.

3. Documentation of all discussion regarding implications, prognosis, prenatal diagnosis and follow up plans.
4. The patient receives sufficient information to make a knowledgeable decision.
5. The cardiotocography which has been interpreted is signed by the doctor and kept in the patients notes.

Compliance to practice standards (Std: 100%)

18.4 Standard

Procedures are performed when necessary by qualified trained staff.

Intent of 18.4

1. Informed consent is obtained from the patient regarding risks and benefits of a procedure. Counselling is performed by MFM specialist or consultant.
2. Limitation of procedures is explained.
3. Procedures are performed by MFM specialist or consultant. Trained staff must assist the operator.
4. Procedures are performed using aseptic technique and under ultrasound guidance.
5. Blood tests, urine tests etc specimens are taken by trained staff and sent to the relevant laboratories.
6. Therapeutic procedures such as amnioinfusion, amnioreduction and aspiration of body cavities are performed after completion of 2 doses of IM dexamethasone 12mg, and a one day course of oral brianal 250mg tds and oral EES 400mg bd. A ventilator is booked.

7. Possible complications and follow up plan is explained to the patient.

Measurable elements of 18.4

1. Consent form is read and signed by patient in the presence of a witness.
2. Documentation of procedure being performed is kept in her notes.
3. All investigations requested are accompanied by a written request form
4. A written follow up plan and appointment is made.

Compliance to practice standards (Std: 100%)

18.5 Standard

Referrals and liaison with other departments when more specialized care is required.

Intent of 18.5

1. Patients with fetal neurological abnormalities will benefit from a fetal MRI to establish diagnosis with more certainty.
2. Patients with medical problems are referred to the combined clinic for physicians input.
3. Perinatal Services Unit meetings are held on a weekly basis to discuss management and plan delivery with the neonatologists.
4. Patients who have emotional issues are referred to a psychiatrist.
5. Liaison with paediatric surgeons when the fetus will most likely require surgery soon after birth.

6. Liaison with pathologists if a post mortem of the baby is needed at birth.
7. Fetuses with cardiac problems are referred to paediatric cardiologists in IJN for fetal echo, and for planning of further management of baby at birth.

Measurable elements of 18.5

1. Written requests for fetal MRI (radiology form)
2. Written referrals to other departments with a copy of referral letter kept in the patients notes.
3. Perinatal Services Unit meeting minutes are documented and kept in a file.

Compliance to practice standards (Std: 100%)

18.6 Standard

Results of investigations aid/confirm the diagnosis.

Intent of 18.6

1. All investigation results will be traced prior to the patient's appointment.
2. If results are significant and available earlier than the patients appointment, the patient is contacted by telephone and an earlier appointment is arranged.
3. All results are interpreted and explained by an MFM specialist or consultant.

Measurable elements of 18.6

1. All investigation results are written reports and a copy is kept in the patients notes.
2. A copy of all prenatal diagnostic results is kept in a file in the clinic.

Compliance to practice standards (Std: 100%)

18.7 Standard

A systematic admission process is in place.

Intent of 18.7

1. Patients who require admission are admitted via the PAC.
2. All patients for admission need to have admission form (Borang Arahan Kemasukan Wad – JRP 3/94(Pin. 1/06) and to be registered at the admission registration counter.
3. If the patient is acutely unwell, registration in the PAC will be carried out by the clinic staff and she will be transported directly to the labour room, high dependency ward (HDW) or one of the general wards.

Measurable elements of 18.7

1. Admission forms are filled out by a doctor.
2. The dedicated staffs will facilitate admission processes for patients who require in-patient treatment.
3. The admission processes will comply with the agreed admission procedures.

Compliance to practice standards (Std: 100%)

18.8 Standard

After full assessment, patients not requiring further MFM care are discharged.

Intent of 18.8

1. Patients who do not need further MFM care will be discharged from the MFM clinic either to the antenatal clinic, health clinic or private doctors.

2. A summary of their care will be documented in the patient's antenatal book.
3. A feedback letter is sent to the referring doctor.
4. For patients who have never been seen in the health clinic, advice will be given to be booked to the closest clinic to their home.
5. A referral letter will be given to the patient if the patient is being discharged to a different state.

Measurable elements of 18.8

1. Documentation of patients care is written in her antenatal book.
2. A copy of all correspondence will be kept in her notes.

Compliance to practice standards (Std: 100%)

18.9 Standard

High risk pregnancies patients receive MFM specialist care.

Intent of 18.9

1. Patients identified as high risk (either maternal, fetal or both) are referred to MFM.
2. High risk patients who were already seen in MFM clinic will continue to be seen by MFM while they are in patients.
3. MFM specialist will perform regular ward rounds in the antenatal wards to oversee management of high risk patients.

4. High risk patients who may require other procedures during caesarean section (eg placenta accreta), MFM specialist will perform caesarean section.

Measurable elements of 18.9

1. High risk women are identified and managed by MFM specialist.
2. MFM specialist sees all patients referred.

Compliance to practice standards (Std: 100%)

18.10 Standard

The MFM unit is involved in training and education.

Intent of 18.10

1. The MFM specialist is responsible in the teaching of all the nurses/MAs, house-officers, medical officers, specialist and other consultants form the department in all areas of O&G but more so in the area of Maternal Fetal Medicine.
2. The MFM specialist is senior enough and if he/she has been gazzetted as a MFM specialist by the MOH will also be in charge of training junior MFM trainees from the MOH hospitals. The teaching will cover theory and practical aspects of MFM.
3. The MFM specialist will organise regular courses for all categories of staff in the field of MFM.
4. The MFM specialist will also be in charge of the level 1 obstetric ultrasound training program for paramedics.

Measurable elements of 18.10

1. Number of courses conducted by MFM unit.
2. Number of medical officers attached to MFM unit.
3. Number of MFM trainees attached to MFM unit.

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

18.11 Standard

The MFM unit participates in research.

Intent of 18.11

1. The MFM unit will keep a database of all the cases that are seen in the said areas. This will be incorporated into the annual report of the department.
2. The MFM specialist will initiate and oversee research projects in his area on a regular basis. He will get the junior doctors to help him with this. There must be at least one study done in his area presented in a national conference. Publication of articles from his area should also be made a priority.

Measurable elements of 18.11

1. MFM annual report is published.
2. Number of publications produced by MFM unit.

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

18.12 Standard

All administrative and clinical services in the MFM unit run efficiently.

Intent of 18.12

1. The MFM specialist will be directly under the Head of Department (unless he or she himself/herself is the head of department), in terms of running the related activities, financial matters, requests of equipments and staff etc.
2. The MFM specialist will be in charge of all the equipment (e.g., ultrasound machines etc.) in his area.
3. Ensure that regular audit activities are held to improve the services that are offered.
4. The MFM specialist will from time to time attend meetings which are related to the provision of MFM services at various levels (hospital, state and national). This includes perinatal, maternal mortality meetings.

Measurable elements of 18.12

1. Number of audits performed.
2. Minutes of all meetings are kept in a file.
3. All documentation with regards to equipment and service history is kept in a file.

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

18.13 Criteria And Timing Of Referrals

1. The following patients should be referred before 11-12 weeks:
 - a. Both parents are Thalassaemia carriers.
 - b. Recurrent miscarriage.
 - c. Multiple pregnancies.

2. The following patients should be referred at 15-16 weeks:
 - a. Maternal age > 35 if woman wishes to have prenatal diagnosis (eg amniocentesis).
 - b. Previous baby with chromosomal abnormality eg Trisomy 13, 18, 21.

3. The following patients should be referred at 18-22 weeks:
 - a. Maternal age > 40 years.
 - b. Diabetes prior to pregnancy.
 - c. Previous abnormal baby or intrauterine death.
 - d. Exposure to teratogenic agents in the 1st trimester.
 - e. Congenital heart disease.
 - f. Severe hypertension, severe IUGR in previous pregnancy.
 - g. Epilepsy on anti-epileptic medication.
 - h. Exposure to chicken pox before 20 weeks gestation.

4. The following patients should be referred at any time (as soon as problem detected):
 - a. AFI < 8 or > 25
 - b. IUGR requiring Doppler assessment.
 - c. Any abnormality detected by scan.
 - d. Rhesus isoimmunisation.

19.0 REPRODUCTIVE MEDICINE

Standards

19.1 Introduction

19.2 Organisational And Administrative Responsibilities

A Reproductive Medicine (RM) subspecialist should head the Reproductive Medicine Unit and will be answerable to the Head, Department of Obstetrics and Gynaecology and undertake full responsibility of running the unit.

19.3 Clinical Responsibilities

19.3.1 The scope of clinical services provided should include Diagnostic, Therapeutic and Management components of Reproductive Medicine.

19.3.2 The diagnosis, counselling and management of patients are directed by the Reproductive Medicine subspecialist or fellow in Reproductive Medicine.

19.3.3 The therapeutic range of surgical and non surgical techniques or the management of patients with fertility and reproductive endocrinology problems must be made available to ensure that patients receive not only appropriate but timely therapy.

19.4 Fertility Clinic

19.4.1 Patient shall be seen in the Reproductive Clinic on an appointment basis.

19.4.2 At the fertility clinic the patient's first appointment will be the fertility counsellor.

- 19.4.3 All relevant patient record shall be made available before the start of clinic sessions. Patient records shall be kept confidential.
- 19.4.4 A dedicated staff nurse termed as Fertility Nurse Coordinator shall manage this clinic on an appointment basis.
- 19.4.5 Blood taking should be done in a specified room; by the phlebotomist (staff nurse or medical laboratory technician). Procedures for collecting, identifying, handling, safely transporting, and disposing of specimens are followed.
- 19.4.6 Patient at the Fertility Clinic shall be counselled regarding causes of infertility, fertility medication and assisted reproduction techniques.
- 19.4.7 Patient planned for follicular tracking will have a baseline trans vaginal scan (TVS) on Day 2 of periods to check for residual cyst and subsequently follicular tracking on Day 8, 10, and 12 until optimal size between 17 to 19mm per follicle.
- 19.4.8 IUI requires husband semen to be sent to the Andrology laboratory for processing under aseptic technique.
- 19.4.9 Consent for IUI is taken. General consent for treatment, if obtained when a patient is admitted as an inpatient or is registered for the first time as an outpatient, is clear in its scope and limits.

19.4.10 IUI is done under aseptic techniques in a treatment room after verification of semen sample of patient's husband.

19.4.11 Luteal support is given

19.5 Menopause clinic

19.5.1 Patients are referred to the menopause clinic after confirmation

19.6 ART centre

19.6.1 ART laboratory is made up of three areas. Andrology laboratory, embryology laboratory and cryopreservation area are fully accredited.

19.6.2 At the end of the day, the clinic doors shall be locked and the keys held by a designated staff member.

19.7 Academic And Educational Responsibilities

This training should include theoretical and practical updates to ensure that the team continues to provide current and appropriate treatment in the management of the patients under their care.

19.8 Audit And Research Responsibilities

The Unit will be responsible for identifying, facilitating, advising and monitoring research and studies related to Reproductive Medicine. This should include conducting clinical audit, feedback and utilization of data collection systems.

19.9 Public Educational Responsibilities

Support groups comprising patients, public, NGO's and should be encouraged. Formation of local support groups should also be encouraged.

19.10 Fellow in Reproductive Medicine (refer page 114)

19.1 INTRODUCTION

Reproductive Medicine as a subspecialty in Obstetrics and Gynaecology involves the management of complex problems relating to Reproductive Endocrinology. This should be in a setting wherein essential diagnostic and therapeutic resources are available and being used appropriately.

Subspecialists in reproductive medicine should have a broad knowledge of endocrine and fertility problems in female and male patients. They must be clinically competent in reproductive endocrinology and the surgery techniques in Reproductive Medicine. They should be involved in basic and applied investigation in reproductive endocrinology and should be able to provide a consultancy service to other obstetricians and gynaecologists. They must be clinically competent in methods of assisted conception, stimulation protocols, ovum pick up, embryo transfer and knowledge of In vitro Fertilization as well as Intra Cytoplasmic Sperm Insemination.

They should also be able to supervise and integrate the provision of Family Planning Services in the hospital and community setting and manage women with menopause, menorrhagia and Adolescent Gynecology. In addition they should be able to interact with social services and other agencies in matters pertaining to reproductive health.

19.2 ORGANISATIONAL AND ADMINISTRATIVE RESPONSIBILITIES

19.2 Standard

A Reproductive Medicine (RM) subspecialist should head the Reproductive Medicine Unit and will be answerable to the Head, Department of Obstetrics and Gynaecology and undertake full responsibility of running the unit.

Intent of 19.2

1. He / She should be gazetted subspecialist with minimally 3 years training in this subspecialty, qualified by training and experience and overall his administrative responsibility for the provision and organization of clinical services related to Fertility and ART, Menopause, Menorrhagia, Family Planning and sterility as well as Adolescence Gynaecology.
2. An appropriate team including the following should assist him / her
 - a. Reproductive Medicine Subspecialists
 - b. Generalist Consultants
 - c. Generalist Specialists
 - d. Medical Officers
 - e. Specialised Nurses (Fertility, Family planning)
 - f. Sonographers
 - g. Embryologists
 - h. Laboratory Technologists
 - i. Counsellors
 - j. Andrologist
 - l. Immunologist
 - m. Reproductive Physiologist
 - n. Geneticist
 - o. Molecular Biologist
3. The Head of Reproductive Medicine Unit will be responsible for overseeing the daily activities of the unit, financial management, staffing, equipment purchase and others.
4. The RM Subspecialist will be required to attend meetings, which are relevant to the provision of reproductive medicine services at various levels (hospital, state, and national).

5. He / She will also serve as an adviser to the Ministry of Health in matters related to Reproductive Medicine.
6. The unit will function as part of the main Department of Obstetrics and Gynaecology. The Head of Department will have the final say in all matters related to the functioning and direction of the Reproductive Medicine Services.

Measurable Elements of 19.2

1. The Head of Reproductive Unit should be a gazetted sub-specialist in Reproductive Medicine.
2. An appropriate team is always present to handle the reproductive medicine patients.
3. All administrative and clinical services are run efficiently
4. Staffing, financial management and equipments are well documented and supervised.

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

19.3 CLINICAL RESPONSIBILITIES

19.3.1 Standard

The scope of clinical services provided should include Diagnostic, Therapeutic and Management components of Reproductive Medicine.

Intent of 19.3.1

1. The Unit should provide a clinically competent service in the management of endocrine and fertility problems by the Reproductive Medicine Specialist Subspecialist in training/medical officer attached to the unit in the following :-
 - a. Diagnosis and management of pituitary, central nervous system, thyroid and adrenal disease relating to reproduction.
 - b. Diagnosis and management of ovarian disease related to reproduction.
 - c. Management of endocrine deficiency states including spontaneous and induced menopause.
 - d. Assisted conception, including ovarian stimulation and the management of hyperstimulation syndrome, ovum pick-up and embryo transfer.
 - e. Fertility control and family planning
 - f. Expertise in ultrasound of the uterus and ovary for follicle tracking and diagnosis of early pregnancy and its complications
 - g. Management of Sporadic miscarriages and their complications
 - h. Management of Recurrent miscarriages including related counselling.
 - i. Management of Physiological and psychosexual problems related to the menopause.
 - j. Management of Sexual dysfunction.
 - k. Management of Paediatric and Adolescent gynaecological problems.
 - l. Management of Menorrhagia.
2. Surgical expertise :-
 - a. Minimal excess surgery competency level III-IV
 - b. Surgeries related to sterility
 - c. Diagnostic/therapeutic hysteroscopic surgeries
 - d. Transcervical resections
 - e. Ablative methods of surgery

- f. Laparotomy, hysterectomy and staging of benign disorders (endometriosis)
 - g. Robotic surgery
- 3. Management expertise :-
 - a. Waiting time management for patient fulfilled
 - b. Quality assurance process in place for ART lab in all aspects
 - c. Maintenance of databases for all fertility patients
 - d. Maintenance of confidentiality for all fertility patients
 - e. Verification process in place at all stages/levels
 - f. Ensuring regular maintenance of all equipments done within the appropriate time frame.
 - g. Maintenance of appropriate housekeeping- hard copy.
 - h. Appropriate and complete documentation of cases
 - i. Ensuring that trouble shooting in the ART lab is regularly carried out
 - j. Accurate feedback to referral and satellite services.

Measurable elements of 19.3.1

1. All cases referred to the Reproductive Medicine unit are seen by subspecialist or fellow in reproductive medicine
2. Appropriate diagnosis is made and classified according to WHO/ICD criteria
3. Appropriate surgical intervention is carried out
4. All surgical cases are done by or supervised by subspecialist in Reproductive Medicine
5. Fellows in Reproductive Medicine unit need to be supervised in all procedures

6. Initial management for the other disciplines in the Reproductive Medicine unit must be seen by the subspecialist or fellow in Reproductive Medicine.
7. Outline of management in clearly discussed with the patients, husband and relatives (where relevant) and documented in the notes

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

19.3.2 Standard

The diagnosis, counselling and management of patients are directed by the Reproductive Medicine subspecialist or fellow in Reproductive Medicine.

Intent of 19.3.2

1. The RM subspecialist will be actively involved in the management of the full range of reproductive medicine patients.
2. He / she will delegate relevant clinical duties to the consultants, specialists, medical officers, nurses, science officers, embryologist, andrologist and counsellors. This may include clinical assessment of patients, relevant investigations, appropriate treatment and management.
3. The RM team is responsible to ensure that appropriate counselling is made available to the patients under their care. Counselling is a very important aspect in the management of the patient with reproductive medicine problems.
4. General counselling in Fertility and separated session on ART counselling must be given to the respective fertility patient at different stages.

5. Appropriate counselling should be given to patient who seeks contraceptive and sterility procedures together with their failure rates.
6. Patients who are menopausal should be fully counselled prior to commencement of treatment together with the associated side effects
7. At the menorrhagia clinic, patients should be counselled about various options available including medical and surgical techniques
8. Counselling for adolescents should be handled by the subspecialist or by a qualified and credentialed counsellor for adolescent

Measurable elements for 19.3.2

1. Patient must have diagnosis made once seen by subspecialist
2. All fellows in Reproductive Medicine must discuss management of patients
3. Appropriate counselling must be done and documented
4. Initial counselling must be done by subspecialist
5. Patient must countersign appropriate counselling documents

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

19.3.3 Standard

The therapeutic range of surgical and non surgical techniques for the management of patients with fertility and reproductive endocrinology problems must be made available to ensure that patients receive not only appropriate but timely therapy.

Intent of 19.3.3

1. This RM subspecialist is responsible for grooming his/her team to ensure the smooth running of the clinics, ward, daycare facilities and the operating theatres. This should include the following :-
 - a. Fertility Clinic and ART Centre
 - b. Family Planning Clinic
 - c. Menopause Clinic
 - d. Sexual Dysfunction & Andrology Clinic
 - e. Menorrhagia Clinic
 - f. Paediatric and Adolescent Gynaecology Clinic (Combined Clinic)
 - g. Minimal access and Reproductive Surgery
 - h. Robotic Surgery
2. Consultative services should be available in the areas of medical endocrinology, paediatric endocrinology and genetics. There should be mutually complementary active and continuing interaction between these groups. It is essential that another subspecialist with special interest and expertise in the management of male infertility be available. This person should also provide formal education for consultative care for male infertility patients.
3. Ambulatory facilities, including ultrasound and Doppler imaging, must be available to ensure the presence of high quality care for women. The operating rooms must be equipped for endoscopic, ablative and microsurgical procedures.

Measurable elements for 19.3.3

1. The Reproductive Medicine team has to ensure that medical treatment in the first line of management unless otherwise indicated.

2. Patient undergoing ART must be discussed, protocol planned and appropriate appointment date for ART given
3. Multidisciplinary team approach should be displayed
4. Patient for surgical management should be discussed prior to intervention being carried out
5. Appropriate equipments and facilities must be available with service records intact and updated.

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

19.4 FERTILITY CLINIC

19.4.1 Standard

Patient shall be seen in the Reproductive Clinic on an appointment basis.

Intent of 19.4.1

1. All patients seen in the Gynaecology Clinic or referred to that clinic will be given an appointment at the Fertility Clinic to see the Fertility Counsellor within two weeks.
2. The appointment will have a date and time and the patient would be advised to bring along her spouse and this process will take about an hour.
3. Those fees as per the (Medical) Order 1982 would be charged.

Measurable Elements of 19.4.1

1. To ensure that all patient that require assessment for Fertility Care seen in this manner
2. Explanation that they have to be seen as a couple
3. Explanation that it would take one hour
4. Aware of the fees payment

19.4.2 Standard

At the fertility clinic the patient's first appointment will be the fertility counsellor. The specialist clinic shall provide services for all cases that have been referred from the general gynaecology clinic with sub-fertility requiring counselling and assisted reproduction.

Intent of 19.4.2

1. The Fertility counsellor would be a qualified staff nurse with training in counselling and would take a health history of the couple and fills up the blue and pink fertility forms.
2. The fertility counsellor would also gave out the investigation forms and discuss initial modes of treatment. She would subsequently give an appointment to see the doctor within 4 weeks.
3. The Fertility counsellor would explain why bloods, semen analysis and hysterosalpingogram (HSG) are required. The Fertility counsellor would also informs the patient that HSG is done after her menses and an appointment is taken at the Radiology Clinic.

4. The Fertility counsellor would get the doctor to prescribe medications for pain relief and *antibiotics as a stat dose prior to and after the procedure.

Measurable Elements of 19.4.2

1. Fertility counsellor qualified Staff Nurse with training in counselling
2. Fertility forms filled
3. Appointment within 4 weeks
4. Adequate explanation
5. Prescription for medication prior to HSG

Compliance to practice standards (Std: 100%)

19.4.3 Standard

All relevant patient record shall be made available before the start of clinic sessions. Patient records shall be kept confidential.

Intent of 19.4.3

1. The patient's record (s) is a primary source of information on the care process and the patient's progress and thus is an essential communication tool.
2. For this information to be useful and support the continuity of the patient's care, it needs to be available during inpatient care, for outpatient visits, and at other times as needed and kept up to date.
3. Medical nursing and other patient care notes are available to all of the patient's care providers.

4. Organization policy identifies those care providers who have access to the patient's record to ensure confidentiality of patient information.

Measurable Elements of 19.4.3

1. Policy establishes those care providers who have access to the patient's record.
2. The record(s) is available to those providers.
3. The record(s) is up to date to ensure communication of the latest information.
4. Strict confidentiality is maintained

Compliance to practice standards (Std: 100%)

19.4.4 Standard

A dedicated staff nurse termed as Fertility Nurse Coordinator shall manage this clinic on an appointment basis.

Intent of 19.4.4

1. All clinic appointments and referrals would be based on an appointment.
2. The Fertility Nurse Coordinator would give appointment on a first come first seen basis. Women with infertility more than 5 years and mature women would have a priority based on appointment.
3. The priority based appointment would be given after discussion with a subspecialist in Reproductive Medicine

Measurable Elements of 19.4.4

1. First come first seen basis
2. Priority cases verified by subspecialist prior to appointment given

3. Appointment only given by the Fertility Nurse Coordinator

Compliance to practice standards (Std: 100%)

19.4.5 Standard

Blood taking should be done in a specified room; by the phlebotomist (staff nurse or medical laboratory technician). Procedures for collecting, identifying, handling, safely transporting, and disposing of specimens are followed.

Intent of 19.4.5

1. Procedures are developed and implemented for
 - a. Ordering test
 - b. Collecting and identifying specimens
 - c. Transporting, storing and preserving specimens; and
 - d. Receiving, logging-in, and tracking specimens.
2. These procedures are observed for specimens sent to outside sources for testing.

Measurable Elements of 19.4.5

1. Procedures guide the ordering of tests.
2. Procedures guide the collection and identification of specimens.
3. Procedures guide the transport, storage, and preservation of specimens.
4. Procedures guide the receipt and tracking of specimens
5. The procedures are implemented.
6. The procedures are observed when outside sources or services are used.

Compliance to practice standards (std: 100%)

19.4.6 Standard

Patient at the Fertility Clinic shall be counselled regarding causes of infertility, fertility medication and assisted reproduction techniques.

Intent of 19.4.6

Counselling focuses on the specific knowledge and skills the patient and family will need to know to make decisions, participate in their care, and continue care at home. This is in contrast to the general flow of information between staff and that is informative but not of an educational nature. To understand the educational needs of each patient and their family, there is an assessment process that identifies the types of surgeries, other invasive procedures and treatments planned, the accompanying nursing needs, and the continuing care needed following discharge. This assessment permits the patient's care givers to plan and deliver the needed education.

Organization staffs inform and educate patients and families at appropriate times in the care process. Education provided as part of the process of obtaining informed consent for treatment (for example, for surgery and anaesthesia) is documented in the patient's record. Education is also provided to support other care decisions of patients and families. In addition, when a patient or family directly participates in providing care (for example, changing dressings, feeding the patient, administering medications and treatment), they need to be educated.

Once the educational needs are identified, they are recorded in the patient's record. This helps all the patient's caregivers participate in the education process. Each organization decides the location and format for educational assessment, planning, and delivery of information in the patient's record.

Measurable Elements of 19.4.6

1. The educational needs of the patient and family are assessed

2. Educational needs assessment findings are recorded in the patient's record.
3. There is uniform recording of patient by all staff
4. Patients and families learn about how to grant informed consent, if appropriate

Compliance to practice standards (std:100%)

19.4.7 Standard

Patient planned for follicular tracking will have a baseline trans vaginal scan (TVS) on Day 2 of periods to check for residual cyst and subsequently follicular tracking on Day 8, 10, and 12 until optimal size between 17 to 19mm per follicle.

Intent of 19.4.7

1. Patients would require regular follicular tracking to ensure growth of the follicle is between 17 to 19mm.
2. Preferably the desired growth should occur between Day 12 and Day 14 of the current cycle. HCG is given 10000 iu subcutaneous injection 36 hours prior to IUI.

Measurable Elements of 19.4.7

1. Follicular tracking records actual follicle size in both ovaries
2. All tracking stop once follicle reach 17 to 19mm.
3. This should coincide with patient's menstrual cycle.

Compliance to practice standards (std: 100%)

19.4.8 Standard

IUI requires husband semen to be sent to the Andrology laboratory for processing under aseptic technique.

Intent of 19.4.8

Husband semen needs to be at the Andrology laboratory within 30 minutes of ejaculation. The availability of a masturbation room will ensure adequate privacy and hassle free transfer of semen to the laboratory. A trained Medical Laboratory Technician, Science Officer or Andrologist for IUI; may process semen for IUI under aseptic technique.

Measurable Elements of 19.4.8

1. Time taken from ejaculation until specimen received in laboratory is appropriate.
2. Trained staffs process the semen for IUI.
3. It is under sterile conditions.

Compliance to practice standards (std: 100%)

19.4.9 Standard

Consent for IUI is taken. General consent for treatment, if obtained when a patient is admitted as an inpatient or is registered for the first time as an outpatient, is clear in its scope and limits.

Intent of 19.4.9

Many organizations obtained a general consent (rather than rely on implied consent) for treatment when the patient is admitted as an inpatient to the organization or when the patient is registered for the first time as an outpatient. When a general consent is obtained, patients are given information on the scope of the general consent, such as which tests and treatments are included under general consent. Patients are also given information about those tests and treatments for which a separate informed consent will be obtained. The organization defines how a general consent is documented in the patient's record.

Measurable Elements of 19.4.9

1. Patients and husbands are informed as to the scope of a general consent, when used by the organization.
2. The organization has defined how a general consent, when used, is documented in the patient's record.

Compliance to practice standards (std: 100%)

19.4.10 Standard

IUI is done under aseptic techniques in a treatment room after verification of semen sample of patient's husband.

Intent of 19.4.10

The patient is placed in lithotomy position; the doctor wears a non-powdered glove and the vulva and vagina cleaned, and cusco speculum inserted. The processed semen

is withdrawn into an IUI catheter and inserted into the cervical canal after verifying the husband's name. This may be done under ultrasound and is an aseptic technique.

Measurable Elements of 19.4.10

1. Time taken since semen prepared to insemination
2. Asepsis is practiced
3. Verification of semen sample
4. Ensuring catheter is in uterine cavity confirmed with ultrasound

Compliance to practice standards (std: 100%)

19.4.11 Standard

Luteal support is given

Intent of 19.4.11

Patient is asked to take Duphaston 10mg bd. She is asked to come back for a follow up appointment a month later once she misses her cycles.

Measurable Elements of 19.4.11

1. Luteal support given
2. Duration given for
3. Informs missed cycles
4. Follow-up in a month

Compliance to practice standard (std: 100%)

19.5 MENOPAUSE CLINIC**19.5.1 Standard**

Patients are referred to the menopause clinic after confirmation

Intent of 19.5.1

1. The clinic will accept all referral cases from primary, secondary and tertiary care centres.
2. All new patients with appointment at the menopausal clinic will be seen by a Reproductive Medicine fellow or subspecialist in the initial visit.
3. The waiting time for a new appointment will be less than 1 month

4. The clinic waiting time will be less than 30 minutes
5. Patient on follow up would be seen by a specialist or medical officer
6. All laboratory investigation will be taken and the results reviewed by the subspecialist/fellow in reproductive medicine at the initial visit.
7. Counselling is initially done by subspecialist in Reproductive Medicine and the subsequently by the doctor.
8. The indications, benefits and side effects of respective HRT and various options of management would be discussed and explained to all patients by specialist.
9. The plan for each patient would be clearly documented in the folder.
10. Appropriate HRT has to be tailored for all patients
11. Subsequent follow up would be as follow :-
 - a. Initial visit
 - b. 6 weeks later
 - c. Monthly for 3 months
 - d. 3 monthly for a year
 - e. 6monthly for life or until stopping HRT
12. At each visit, the breast and abdomen should be examined
13. Yearly fasting blood sugar, fasting lipid profiles and liver function test must be taken
14. 3 yearly mammogram and pap smear should be done

15. Any abnormality when patient is on HRT shall be managed by a multidisciplinary team consisting of the gynaecologist, breast and endocrine surgeon and oncologist.
16. Patient who are at low risk may continue HRT for life after being counselled
17. High risk patients should not be commenced on HRT but instead treated symptomatically
18. Bone Density (Dexa) scans may be done in some patients with evidence of significant family history or who complain of joint or back pains.

Measurable elements of 19.5.1

1. Waiting time for new appointment
2. Waiting time in clinic to see doctor.
3. Cases seen by subspecialist in reproductive medicine/fellow.
4. Number of investigations sent and reviewed in clinic
5. Audit

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

19.6 ART CENTRE

19.6.1 Standard

ART laboratory is made up of three areas. Andrology laboratory, embryology laboratory and cryopreservation area are fully accredited.

Intent of 19.6.1

The embryologist will oversee all functions, maintenance, quality controls and sterility of the embryo lab and cryopreservation area and report back to Head of Unit.

The andrologist or embryologist will oversee the Andrology lab and report back to Head of Unit. All schedules and daily ongoing must be reported to Head of Unit.

The Fertility Nurse Coordinator is to ensure that appropriate coordination occurs between Reproductive Medicine Consultant / Specialist and anaesthetist as well as the referring doctors/ specialist and consultant from satellite centres.

The Fertility Coordinator Nurse is to ensure that prior to ovum pick up and embryo transfer, the appropriate counselling has been done and that doctors have signed all forms included in the consent.

Only subspecialist or credentialed consultant and specialist are permitted to do ovum pick up and embryo transfer. Specialist in training should be supervised prior to being privileged to do this procedure.

All data needs to be key-in by the end of that day into the fertility database backed up and stored prior to shut down for the day.

All forms and reports need to be filled out, filed and copies sent to respective satellite centers.

Separate surgical operative procedures, quality control protocols, management protocols for ART center stored in soft and hard copy with stringent security and confidentiality exercised.

Measurable elements of 19.6.1

1. Records of patients, maintenance, monitoring of equipments and outcome recorded and stored in database daily.
2. Responsibility of hygiene, sterility of embryology lab, cryopreservation area as well as reproductive treatment area is evident and maintained by embryologist
3. Separate surgical operative protocols available for ART centre
4. Appropriate co-ordination present between reproductive medicine coordinator, embryologist and andrologist.
5. Documented counselling of patients for all reproductive treatments
6. Appropriate ART forms filled prior, during and post treatment.

19.6.2 Standard

At the end of the day, the clinic doors shall be locked and the keys held by a designated staff member.

Intent of 19.6.2

Facility must be locked at the end of each day. ART Laboratory and Andrology separately locked. Embryologist room with protocol and records separately locked. Medical records in the sister room separately locked. Sister in charge of Fertility Unit would hold the keys. No records or protocols can be removed from this area without Head of Unit permission.

19.7 ACADEMIC AND EDUCATIONAL RESPONSIBILITIES

19.7.1 Standard

This training should include theoretical and practical updates to ensure that the team continues to provide current and appropriate treatment in the management of the patients under their care.

Intent of 19.7.1

The Unit should encourage and provide the opportunity for team members to attend appropriate national and where possible international meetings relevant to their subspecialty annually.

The Unit will also take primary responsibility for preparing and implementing an annual training calendar of training events in Reproductive Medicine. The participants should include members of the private health care system who will be their partners in providing care.

The RM subspecialist should also be responsible for supervising the training of junior staff in the subs-speciality area including full participation in the unit's undergraduate and postgraduate programme.

The RM subspecialist will be responsible for the continued training and education of all members of the Unit.

Measurable elements of 19.7.1

1. Ensure all doctors and staff undergone training and seminars
2. Ensure all doctors and staff attend workshop
3. Ensure all doctors are involved as speakers in seminars and conferences

4. Training Calendar is followed and supervised by Head of Unit for all subspecialist

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

19.8 AUDIT AND RESEARCH RESPONSIBILITIES

19.8.1 Standard

The Unit will be responsible for identifying, facilitating, advising and monitoring research and studies related to Reproductive Medicine. This should include conducting clinical audit, feedback and utilization of data collection systems.

Intent of 19.8.1

The RM subspecialist and his team should aspire to present and publish papers both at national and international levels.

The Reproductive Medicine Unit should maintain a database of patients, treatment and outcome with the necessary security and confidentiality issues in place. The Unit will also be responsible for the preparation of a relevant section in the Departmental Annual Report.

Measurable elements of 19.8.1

1. Types of audits for external or internal
2. Number of audits
3. Correction put in place
4. Re-audits done

5. Number of papers presented/published

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

19.9 PUBLIC EDUCATIONAL RESPONSIBILITIES

19.9.1 Standard

Support groups comprising patients, public, NGO's and should be encouraged. Formation of local support groups should also be encouraged.

Intent of 19.9.1

Reproductive Medicine Issues are of importance to the General Public at large. There is a need to educate and increase public awareness particularly in the preventive measures. The creation of such awareness can be done through public forums, advertisements, public campaign and others.

Measurable elements of 19.9.1

1. Outcome of public education
2. Outcome of support groups
3. Types of advertisements
4. NGO support number

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

19.10 FELLOW IN REPRODUCTIVE MEDICINE

A) Administrative

1. To assist the head of the unit in carrying out administrative duties.

2. To carry out non clinical duties as directed by the head of the unit, the head of department, or the hospital director.
3. To organize continuous medical education for the personals of the department
4. To attend talks, seminars, courses, and conferences to improve and update knowledge.
5. To plan and organize the ART discussion.
6. To participate in, and implement departments CME activities, QA activities, research projects, patient satisfaction studies, innovation and key performances indicators.
7. To assist in the organization of the departments courses.

B) Clinical

1. To conduct assessment of the patients and plan a treatment plan for the patient.
2. To provide effective efficient and professional Reproductive Medicine services.
3. To assist during the surgeries performed by Reproductive Medicine Subspecialist.
4. To counsel patients on the nature of the disease, its sequels, the treatment options, complication of treatment, outcome.

5. To obtain the necessary consent for surgical intervention and blood transfusion.
6. To assist in the end of life care of the patient so as to ensure a dignified death.
7. To provide professional clinical leadership and supervision to the medical officers.
8. To undertake call duties as per roster
9. To be up to date with the trends and development in reproductive medicine by keeping abreast of relevant literature conferences and courses.

20.0 UROGYNAECOLOGY

Standards

20.1 Introduction

20.2 Clinical Responsibility

20.2.1 Urogynaecology clinic

All patients with urogynaecological problems will be referred to the urogynaecology clinic

20.2.2 Urodynamic studies

All patients will be seen by a subspecialist

20.2.3 Urogynaecology Operation Theatre

All urogynaecological patients planned for operation will be seen by subspecialist

20.3 Administrative Responsibilities

The urogynaecologist is the head of the urogynaecological unit/team.

20.4 Education and Research Responsibility

Teaching and training of staff

20.5 Public Awareness and Support Group

The urogynaecologist is responsible to create public awareness relating to incontinence and pelvic organ prolapsed

20.6 Relationship with the Department of O&G

The urogynaecological unit will function within the ambit of the Department of O&G.

20.1 INTRODUCTION

The subspecialty of urogynaecology, involves management of female urinary incontinence & pelvic floor dysfunction. It involves team work (Urogynaecologist, continence nurses & physiotherapist) and at times multidisciplinary team involvement (urologist, colorectal surgeons & geriatrician). The area of clinical services involves both diagnostic as well as therapeutic components. A urogynaecology unit comes under the purview of the Department of Obstetrics & Gynaecology of the Hospital concerned. In order to provide adequate subspecialist services and maintain competence of the urogynaecologist, at least 70% of this unit's work should be mainly urogynaecological work. The other 30% of the time should be allocated for other general gynaecological work and obstetrics.

The urogynaecology unit will deal with all problems with regards to female urinary incontinence in association with pelvic floor dysfunction. Any other urological problems will be dealt with by the Department of Urology or General Surgery in the absence of such a department.

20.2 CLINICAL RESPONSIBILITY

20.2.1 Urogynaecology clinic

Standard

All patients with urogynaecological problems will be referred to the urogynaecology clinic

Intent of 20.2.1

1. All patients referred to the urogynaecology clinic will be seen by the subspecialist

2. All new appointments will be seen within one month
3. All other follow up cases will be seen according to the severity of cases
4. The payment for the patients would be RM 13 for foreigners, RM 5 for government staffs and RM 30 for referral from general practitioners. (Fees Act)
5. All the patients in the clinic will be seen within 1 hour from the appointment time.
6. All patients would be counselled regarding their problems and the plan of management clearly documented in the folder.
7. The relatives of the patients would also be counselled

Measurable elements of 20.2.1

1. Consultation by subspecialist
2. New appointments within 1 month
3. Fees paid
4. Presence of relatives
5. Consultation given to patients
6. Waiting time in clinic

Compliance with practice protocols (std: 100%)

20.2.2 Urodynamic Studies

Standard

All patients will be seen by a subspecialist

Intent of 20.2.2

1. Waiting time will be less than 45 minutes
2. All cases will be seen by sub specialist
3. Fees paid RM 13. (Fees Act)
4. The decision for the study is made by specialist and limited for patients who have not responded to routine management.
5. The patients would be consulted and the condition, prognosis and plan of management clearly explained to the patients and documented in the folders.
6. Relatives of the patient would also be counselled.

Measurable elements of 20.2.2

1. Indications for urodynamic studies
2. Consultation by sub specialist
3. Waiting time in clinics
4. Presence of relatives
5. Explanation to patients

6. Relatives counselled

Compliance to practice standards (std: 100%)

20.2.3 Urogynaecology Operation Theatre

Standard

All urogynaecological patients planned for operation will be seen by subspecialist

Intent of 20.2.3

1. All decisions for urogynaecological operative procedures must be made by subspecialist
2. Time from decision to operation would be less than 6 months
3. All patients would be counselled regarding the indication, the operative procedure and associated complications.
4. Consultation would be made by the urogynaecological team
5. The relatives would also be explained regarding the planned procedure and associated risk

Measurable elements of 20.2.3

1. Review by subspecialist
2. Waiting time from decision of surgery till operation
3. Counselling of patients

4. Consent from patients
5. Presence of relatives

20.3 ADMINISTRATIVE RESPONSIBILITY

Standard

The urogynaecologist is the head of the urogynaecological unit/team.

Intent of 20.3

1. He/she is responsible of smooth running of this unit, which comprises a consultant, specialist, medical officers, continence nurses & physiotherapist and support group aided by voluntary staff from NGOs.
2. The urogynaecologist will be responsible as the head of urogynaecological services, for running the daily activities of the unit, financial management, staffing, equipment purchase and others.
3. Ensure the smooth running of urogynaecological clinic, ward, daycare centre & operating theatre.
4. The urogynaecologist from time to time will attend meetings which are relevant to the provision of the urogynaecological subspecialty at various levels (hospitals, state, and national).

Measurable elements of 20.3

1. The unit is headed by a urogynaecologist
2. Urogynaecology activities supervised and administered by urogynaecologist.

3. Equipment, staffing, financial balance are accredited by Head of O&G Department.

Compliance with practice protocols (std: 100%)

20.4 EDUCATION & RESEARCH RESPONSIBILITY

Standard

Teaching and training of staff

Intent of 20.4

1. The urogynaecologist is responsible in providing the necessary teaching and education to all the members of the unit. This includes the consultants, specialist, trainees, medical officers, house officers, continence nurses & physiotherapist and the support groups.
2. The urogynaecologist is responsible to provide theoretical and practical knowledge to the subspecialist trainees.
3. The urogynaecologist and the team is responsible to organize regular courses for all categories of staff. The suggested courses are perineal & episiotomy workshop, 3rd & 4th degree tear repair workshops and others.
4. The urogynaecological unit will also from time to time provide teaching & training for doctors from the private sector.
5. The urogynaecology unit should keep a database of all the cases that are seen. This would be incorporated into the annual report of the department.

6. The urogynaecologist and the team should initiate and oversee research projects on a regular basis. There should be an aim to present at least one study at the national or international level. The publication of articles in urogynaecology should be made regularly.

Measurable elements of 20.4

1. Courses and seminars organized by the urogynaecology unit
2. Adequate training of staffs
3. Departmental report and database
4. Number of presentations and publications

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

20.5 PUBLIC AWARENESS & SUPPORT GROUP

Standard

The urogynaecologist is responsible to create public awareness relating to incontinence and pelvic organ prolapsed

Intent of 20.5

1. With increasing life expectancy, urogynaecological problems have now become the most common chronic medical condition in women. This problem is much more common than hypertension, diabetes and psychoses.
2. The creation of awareness can be done through public forums, advertisements, public campaign and others.

3. Support groups comprising patients, public, NGO's and continence advisors should be encouraged. Formation of local support group should be encouraged to improve the quality of life of our aging population.

Measurable elements of 20.5

1. Public forums and awareness campaigns
2. Support groups
3. Patients awareness and understanding

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

20.6 RELATIONSHIP WITH THE DEPARTMENT OF O&G.

Standard

The urogynaecological unit will function within the ambit of the Department of O&G.

Intent of 20.6

1. The urogynaecologist will share calls in the Department of O&G until such a time when there are sufficient Advanced O&G subspecialists to handle obstetric calls.
2. Similarly all support staff such as medical officers and nurses will form part of the Department and will be multifunctional when required in the general interests to do so.

3. The staff of the urogynaecological unit will support the Department of O&G's effort to be an accredited department according to MSQH standards, ISO standards and to be a Baby Friendly hospital. Towards this end, the staff will develop guidelines and protocols for use in urogynaecology.
4. The urogynaecologist will ensure that all formats and forms in use in the Department of O&G are uniformly used in the Urogynaecology Unit. Any new formats or forms developed for use in urogynaecology must be approved the Head of Department.
5. The Head of Department of O&G will have the final say in all matters related to the functioning of the Urogynaecology Unit.

Measurable elements of 20.6

1. Standardization of protocols and policies
2. Meetings with consultants and head of department

Compliance with practice protocols (Std: 100%)

21.0 GYNAE-ONCOLOGY

Standards

INTRODUCTION

21.1 ADMINISTRATION

- 21.1.1 A trained Gynae-oncologist heads the unit, and is responsible for the day to day functioning of the unit.

21.2 WARD

- 21.2.1 Patients are admitted to receive inpatient care
- 21.2.2 A subspecialist or a trainee in Gynae-oncology is responsible for the patient's care in the wards.
- 21.2.3 The patient and their families are kept informed
- 21.2.4 Referral, Discharges and Follow Up
There is a policy guiding the appropriate referral and discharge of patient

21.3 SURGERY

- 21.3.1 Each patient surgical care is planned and documented based on the results of the assessment.
- 21.3.2 The risk, benefits and alternative options are discussed with the patient and his or her families or those who make decisions for the patients.

21.3.3 The surgery performed is documented in the case notes.

21.3.4 Patient care after surgery is planned and documented.

21.4 CHEMOTHERAPY SERVICES

21.4.1 Chemotherapy services are available to meet patient's needs, and all such services meet applicable local and national standards, laws, regulations and professional standards.

21.4.2 A qualified Gynae-oncologist is responsible for managing the chemotherapy services.

21.4.3 Department protocols guides the care of patients undergoing chemotherapy.

21.4.4 A qualified individual conducts a pre-chemo assessment.

21.4.5 Each patient's chemotherapy is planned and documented

21.4.6 Each patients post chemotherapy status is monitored and documented and the patient is discharged by a qualified individual or by using established criteria.

21.5 DAY-CARE CHEMOTHERAPY

This service is available for a few selected, safe chemotherapy drugs.

21.6 RADIOTHERAPY

Patients in need of radiotherapy are referred to the radiotherapist.

21.7 COLPOSCOPY CLINIC

Patients are attended to in this clinic for management of pre-invasive cervical lesions.

21.8 MOLAR CLINIC

Patients with molar pregnancies are managed, and have surveillance follow up in this clinic.

21.9 GYNAE-ONCOLOGY NEW CASES CLINIC

New gynae-oncology patients are seen for the first time in this clinic

21.10 CANCER PREVENTION PROGRAM

The Gynae-oncologist is responsible for all activities related to female genital cancer prevention program.

21.11 TUMOUR BOARD PRESENTATION

Tumour board meeting is a multi-disciplinary activity of the Gynae-oncology unit, held monthly.

21.12 ACADEMIC AND TRAINING RESPONSIBILITY

The Gynae-oncology unit will be a centre of excellence for training individuals in the field of Gynae-oncology

21.13 RESEARCH RESPONSIBILITY

Gynae Oncologist is responsible for research and audit.

21.14 STAFF-ROLES AND FUNCTIONS

INTRODUCTION

The gynaecology unit consists of the gynae-oncological subspecialist and fellow in gynaecology. This unit is responsible in managing all gynae-oncological patients either in the ward, clinic or in the operational theatre.

21.1 ADMINISTRATION

21.1.1 Standard

A trained Gynae-oncologist heads the unit, and is responsible for the day to day functioning of the unit.

Intent of 21.1.1

1. The unit is headed by a Gynae-oncologist whose responsibilities includes :-
 - a) administrative activities including financial, equipment acquisitions, staffing etc
 - b) clinical and cancer preventive services
 - c) academic and research responsibilities

Measurable Elements of 21.1.1

1. The unit is headed by a Gynae-oncologist.
2. The gynae-oncologist is trained in various aspects of his discipline.
3. The gynae-oncologist is responsible in addressing elements a) through c)

Compliance with practice protocols (Std: 100%)

21.2 WARD

21.2.1 Standard

Patients are admitted to receive inpatient care.

Intent of 21.2.1

1. Patients are admitted to the ward for various reasons and includes :-
 - a) outstation referrals, requiring input by the Gynae-oncologist,
 - b) admissions for elective surgeries,
 - c) for stabilization of medical co-morbid prior to surgery
 - d) for chemotherapy
 - e) myelo-suppressed patients,
 - f) complications secondary to gynecological cancers.
2. Ill patients in need of urgent care are given priority for assessment and treatment. Patient's need for palliative care or curative care, are prioritized based on the patient condition at the time of admission.

Measurable elements of 21.2.1

1. Patients requiring inpatient treatment are admitted.
2. Ill patients are given priority in care.
3. The need for palliative or curative care is decided at admission.

Compliance with practice protocols (Std: 100%)

21.2.2 Standard

A subspecialist or a trainee in Gynae-oncology is responsible for the patient's care in the wards.

Intent of 21.2.2

On admission to the ward, the patient will be examined and clerked by medical officer. The patient is then assessed by the Gynae-oncologist or the Fellow in Training. The management of the patient at all stages is led by the Gynae-oncologist. All findings are documented.

Measurable element of 21.2.2

1. Qualified individuals care for the patient in the ward.
2. Management is Gynae-oncologist led.
3. All findings are documented.

Compliance with practice protocols (Std: 100%)

21.2.3 Standard

The patient and their families are kept informed

Intent of 21.2.3

1. On admission, the patient and their families receive information regarding :-
 - a. the diagnosis and prognosis
 - b. the proposed care
 - c. the expected outcome
 - d. the expected cost of treatment, in selected cases.
2. The unit supports the patient's and their family's rights, to participate in the care process, and to a respectful and compassionate care at the end of life. All this process is documented.

Measurable Elements of 21.2.3

1. The Patient and their next of kins are provided information addressing element :-
 - a. through
 - b. of the intent statement
2. The unit supports the right, to a respectful and compassionate care at the end ofb life.
3. All information provided is documented
4. Appropriate counselling is given and documented.

Compliance with practice protocols (Std: 100%)

21.2.4 Standard**Referral, Discharges and Follow Up**

There is a policy guiding the appropriate referral and discharge of patient

Intent of 21.2.4

There is a policy guiding the appropriate referral or transfer of patients to another organization to meet their continuing care and needs. Before transferring or referring a patient, the unit determines that the receiving organization can meet the patients continuing care needs. The receiving organization is given a written summary of the patient clinical condition. During transfer, a qualified staff member monitors the patient's condition. The transfer process is documented in the patient's record. A copy of the discharge summary is kept in the record for future references. Patients and where appropriate, their families, are given 'follow up' instruction at discharge or referral.

Measurable Elements of 21.2.4

1. There is a policy guiding the appropriate referral or discharge of patient
2. The referral or discharge is based on the patients needs for continuing care.
3. The referral is accompanied with a written summary.
4. The transfer or discharge process is documented.
5. Patients' record contains a copy of the discharge summary.
6. Patients and their families are given follow up instructions.

Compliance with practice protocols (Std: 100%)

21.3 SURGERY**21.3.1 Standard**

Each patient surgical care is planned and documented based on the results of the assessment.

Intent of 21.3.1

As gynae-oncology surgery carries a high level of risk, it needs to be carefully planned. The patient's assessment is the basis for selecting the appropriate surgical procedure. Procedure selected depends on the patient's clinical features, physical status, and the diagnoses. The risk and benefits of the procedure are taken into consideration. The surgical care planned, and its indications are documented in the patient's records. .

Measurable elements of 21.3.1

1. Gynae-oncology surgery is adequately planned.

2. The planning considers all available assessment information.
3. An appropriate surgery is planned based on the assessment.
4. Prior to the procedure, a preoperative diagnosis is documented.

21.3.2 Standard

The risk, benefits and alternative options are discussed with the patient and his or her families or those who make decisions for the patients.

Intent of 21.3.2

1. Patient and their families or decision makers, receive adequate information to participate in the case decisions and provide the informed consent.
2. The information includes
 - a. The surgical and non surgical options.
 - b. The risks of the planned procedure and remedial measures.
 - c. Side effects of the surgery, for example loss of fertility, amenorrhoea and surgical menopause which can affect the quality of life of the patient.
 - d. Other complications for example wound breakdown and infections.
 - e. Adjuvant treatment, for example chemotherapy, and the side effect of this treatment.
 - f. The type of surgical scar
 - g. The possible need to transfuse blood and blood products, and its complication.

These could range from minor allergic reactions to the risk of transmission of infectious diseases, even though remote, are informed.

3. This information is provided to the patients or their relatives by the gynae-oncologist or any other individual qualified to do so. The gynae-oncologist is also responsible for obtaining consent, for the surgery. Patient at added risk, due to associated medical co-morbid are required to sign high risk consent. This consent is obtained from the family members. All the information provided and queries answered are documented in the patient's case notes.

Measurable elements of 21.3.2

1. Adequate preoperative counselling is provided and options discussed.
2. Consent for the surgery is taken by the gynae-oncologist or the fellow in training.
3. High risk consent is required for those at added risk.
4. The whole process is documented.

Compliance with practice protocols (Std: 100%)

21.3.3 Standard

The surgery performed is documented in the case notes.

Intent of 21.3.3

The findings during surgery are very important, both for the short and long term management of the patient and it must be correctly written. The patients operative notes includes :-

- a. the post-operative diagnosis,
- b. a description of the surgical procedure and the findings.
- c. the surgical specimens sent.
- d. the names of the surgeon, assistant, and staff-nurse must be written.

- e. the date, time of commencement and completion of surgery must be documented.
- f. post operative instructions will include the intravenous fluid regime, analgesia, antibiotics if any with its dosage.

Measurable elements of 21.3.3

- 1. A post operative diagnosis is documented
- 2. A description of the surgical procedure, findings, and any surgical specimen sent, is documented
- 3. The names of the surgeon and surgical assistants are documented.

21.3.4 Standard

Patient care after surgery is planned and documented.

Intent of 21.3.4

Each patients post surgical care is different, and therefore it is important that it is carefully planned out. The Post operative instructions include the intravenous fluid regime, analgesia, antibiotics if any, with its dosage. The post operative planned care is documented in the case notes.

Measurable elements of 21.3.4

- 1. Each patients post operative care is planned.
- 2. The plan is documented in the patient's record.

Compliance with practice protocols (Std: 100%)

21.4 CHEMOTHERAPY SERVICES

21.4.1 Standard

Chemotherapy services are available to meet patient's needs, and all such services meet applicable local and national standards, laws, regulations and professional standards.

Intent of 21.4.1

The department provides both in-ward and day-care chemotherapy for patients. These services meet all the applicable local and national standards, laws and regulations and professional standards.

Measurable elements of 21.4.1

1. Chemotherapy services meet applicable local and national standards, law and regulations
2. Chemotherapy services are available to meet patient needs.
3. Both in-patient and day care services are provided.

Compliance with practice protocols (Std: 100%)

21.4.2 Standard

A qualified Gynae-oncologist is responsible for managing the chemotherapy services.

Intent of 21.4.2

Chemotherapy services are under the directive of a qualified gynae-oncologist who has been gazetted by the Ministry of Health Malaysia. He assumes professional responsibility for the chemotherapy services provided. Responsibilities include:

- a) Developing and updating Chemotherapy protocols
- b) Maintaining quality control programs

- c) Individualizing the type of chemotherapy needed for a particular individual
- d) Attending to any complications from chemotherapy
- e) Preparing statistics pertaining to chemotherapy administration.

Measurable elements of 21.4.2

1. Chemotherapy services are under the direction of a qualified Gynaecologist
2. Responsibilities includes those elements from a) through e) in the intent statement.

Compliance with practice protocols (Std: 100%)

21.4.3 Standard

Department protocols guides the care of patients undergoing chemotherapy.

Intent of 21.4.3

1. Chemotherapy poses risk to patients, and thus needs to be provided using clear definitions policies and procedures. Chemotherapy may cause life threatening anaphylaxis, myelo-suppression and various other complications. Important consideration includes the patient's ability to withstand the toxicities, availability of life saving medications and resuscitation set-up. Chemotherapy protocols outlines :-
 - a. Indication and type of chemotherapy for a particular condition
 - b. Hematological and biochemical criteria's to be fulfilled before administering chemotherapy
 - c. Drug dosages calculation formulas
 - d. Patient monitoring, criteria's.
 - e. Dosage and frequency of drugs.
 - f. Hydration regimes

2. The unit ensure the presences of skilled staff, during chemotherapy administration, competent in :-
 - a. appropriate monitoring
 - b. response to complication especially to anaphylaxis and myelo suppression.
 - c. at least basic life support capabilities.

Measurable elements of 21.4.3

1. Appropriate policies, procedures and protocol addressing elements (1a) through (1f) found in the intent statement guides the patients undergoing chemotherapy. The qualified individual identified in gynae-oncology (refer standard 21.1.1) participate in the development of this policies, procedures and protocol
2. There is an assessment of appropriateness for chemotherapy prior to administration.
3. The qualified practitioner responsible for the chemotherapy is qualified in at least elements (2a) through (2c) in the intent statement.
4. Responsibilities includes planning the type of chemotherapy needed for a particular individual.
5. Responsibilities includes attending to any complications from chemotherapy.
6. Responsibilities include preparing statistics pertaining to chemotherapy administration.

Compliance with practice protocols (Std: 100%)

21.4.4 Standard

A qualified individual conducts a pre-chemo assessment.

Intent of 21.4.4

As chemotherapy poses risk to patients, its administration is carefully planned. The patients hematological and biochemical indices are the basis for the treatment. A pre chemo assessment provides information regarding :-

- a) Suitability for chemotherapy
- b) Criteria shortfall which needs to be rectified.
- c) Response of the patient in the previous cycle.
- d) The Gynae-Oncologist or qualified individual conducts the pre chemo assessment.

Measurable elements of 21.4.4

1. A pre-chemo assessment is performed for each patient.
2. Hematological and biochemical criteria's is the basis of this assessment.
3. A qualified individual conducts the pre-chemo assessment.
4. Shortfall in criteria is rectified.
5. Findings are documented.

Compliance with practice protocols (Std: 100%)

21.4.5 Standard

Each patient's chemotherapy is planned and documented

Intent of 21.4.5

Chemotherapy administration is carefully planned and documented in the case notes. These include the type of chemotherapy to be given, monitoring procedures, the post chemotherapy plans which includes the investigation to be performed for the subsequent cycle and the dates of admission for the same.

Measurable elements of 21.4.5

1. Each patient's chemotherapy is planned
2. The plan is documented
3. Investigations for subsequent chemotherapy are ordered
4. Dates of admission are given.

Compliance with practice protocols (Std: 100%)

21.4.6 Standard

Each patients post chemotherapy status is monitored and documented and the patient is discharged by a qualified individual or by using established criteria.

Intent of 21.4.6

The patient is monitored for any complication and this is documented. The patient is discharged by the gynae-oncologist. The patient is discharged with forms, for hematological investigation on day 10 post chemo and subsequent pre-chemo investigations. This will form the criteria for ensuing chemotherapy cycle. Date of readmission for subsequent cycle is given. Admission forms are given.

Measurable elements of 21.4.6

1. The patient is discharged by qualified gynae-oncologist.
2. Necessary investigation forms are provided at discharge.

3. Necessary re-admission forms are given.

Compliance with practice protocols (Std: 100%)

21.5 DAY-CARE CHEMOTHERAPY

Standard

This service is available for a few selected, safe chemotherapy drugs.

Intent of 21.5

Chemotherapy drugs with a good safety index can be given on a day care basis. Investigations are ordered and reviewed prior to administration of this agent. In the presence of anemia. Infections or myelo-suppression, the patients will be admitted for corrective measures. If necessary, administration of these drugs will be postponed by a few days. All this medications are given in the gynae-oncology clinic

by a gynaecology trained nurse, under strict supervision of the gynae-oncologist or the fellow in training. In the presence of any complications the patient would be admitted to the ward for further assessment and monitoring. All findings, drugs and dosage are documented.

Measurable elements of 21.5

1. Safe chemotherapy agent may be given on a day-care basis.
2. The gynae-oncologist nurse administer the chemotherapy drugs.
3. The gynae-oncologist supervise the gynae-oncology day care chemotherapy facilities

4. All findings, doses are documented.

Compliance with practice protocols (Std: 100%)

21.6 RADIOTHERAPY

Standard

Patients in need of radiotherapy are referred to the radiotherapist.

Intent of 21.6

Advance female genital cancers, which cannot be managed surgically, are referred for radiotherapy. These cases are discussed with the radiotherapist. Following radiotherapy, these patients are placed on surveillance follow-up at the gynae-oncology unit.

Measurable elements of 21.6

1. Patients are referred to the gynae-oncology unit for radiotherapy
2. After radiotherapy treatment, patients are followed up by the gynae-oncology unit.

Compliance with practice protocols (Std: 100%)

21.7 COLPOSCOPY CLINICS

Standard

Patients are attended to in this clinic for management of pre-invasive cervical lesions.

Intent of 21.7

Patients with pre-invasive lesions of the cervix are seen in this clinic. They are examined by the gynae-oncologist and the fellow in training. The majority of them are referred from other clinics or hospitals, and includes, the private sector. The activities undertaken in the colposcopy clinic are :-

- a) colposcopy examination and biopsies where relevant
- b) treatment procedures such as LLETZ, LEEP.
- c) surveillance Pap smears
- d) medications and advice.
- e) follow up dates and details provided.

All the findings are documented in a pictorial format.

Measurable elements of 21.7

1. Patients with pre invasive lesions are managed in the colposcopy clinic
2. The patients are attended to by the gynae-oncologist or the fellow in training
3. Activities include those addressed in a) through e) in the intent statement.

Compliance with practice protocols (Std: 100%)

21.8 MOLAR CLINIC.

Standard of 21.8

Patients with molar pregnancies are managed, and have surveillance follow up in this clinic.

Intend of 21.8

Persistent gestational trophoblastic disease may develop after a molar pregnancy, a non-molar pregnancy or a live birth. As such, these patients are managed and have surveillance follow up in this clinic. This clinic is held weekly, where patients are attended to by the Medical officer, the Fellow in gynae-oncology training or the Gynae-oncologist. Complicated cases are admitted for monitoring, investigation and commencement of chemotherapy, where indicated. Subsequent cycles of chemotherapy are usually administered on a day care basis. All the findings and results obtained are documented.

Measurable elements of 21.8

1. Patients with molar clinics are followed up in this clinics
2. Qualified individuals are responsible for the care of the patients in this clinic
3. Molar clinic is held weekly
4. Complicated cases are admitted

Compliance with practice protocols (Std: 100%)

21.9 GYNAE-ONCOLOGY NEW CASES CLINIC**Standard**

New gynae-oncology patients are seen for the first time in this clinic

Intent of 21.9

1. New gynae-oncology cancer cases, referred to the unit are attended to in this special clinic, held once a week on Fridays. This is to ensure, that the patients receive adequate attention, and care for their ailments. These clinics are managed exclusively by the gynae-oncologist or the fellow in training; where quality time is spent with these patients to obtain all clinical information necessary to manage these often complicated and difficult cases. The activities at this clinic include :-
 - a) full history taking from these patients.
 - b) general, systemic and perineal examination where indicated
 - c) necessary haematological and radiological investigations
 - d) planning of treatment and
 - e) appropriate counselling of patients and their close family members, in regards to :-
 - i) nature of the disease
 - ii) management options

- iii) prognosis, sequelae
- iv) complications of the disease as well as complications from treatment

2. All these activities are adequately documented.

Measurable elements of 21.9

1. New cases are seen in a special clinic
2. Activities include a) to e) addressed in the intent statement
3. Patients and their families are adequately counselled.

Compliance with practice protocols (Std: 100%)

21.10 CANCER PREVENTION PROGRAM

Standard

The Gynaec-oncologist is responsible for all activities related to female genital cancer prevention program.

Intent of 21.10

The Gynaec-oncologist is responsible for activities related to cancer prevention program and this includes :-

- a) supervision of the pre-invasive clinic and the colposcopy clinic.
- b) review of the histopathology reports and the Pap smear results.
- c) follow up of patients in need of further surveillance.
- d) public campaign and education pertaining to cancer prevention.
- e) staff education and training

Measurable Elements of 21.10

1. The Gynae-Oncologist is responsible for activities related to cancer prevention which is addressed by element a) through e) of the intent statement.

Compliance with practice protocols (Std: 100%)

21.11 TUMOUR BOARD PRESENTATION**Standard**

Tumour board meeting is a multi-disciplinary activity of the Gynae-oncology unit, held monthly.

Intent of 21.11

In this meeting, management issues are discussed together with the pathologist, the radiologist, and the radiotherapist, to reach a consensus on the ideal treatment approach for a patient. All the results of the discussion are clearly documented and implemented.

Measurable Elements of 21.11

1. The unit seeks a multidisciplinary approach for gynae-oncology patients.
2. All discussions are documented

Compliance with practice protocols (Std: 100%)

21.12 ACADEMIC AND TRAINING RESPONSIBILITY**Standard**

The Gynae-oncology unit will be a centre of excellence for training individuals in the field of Gynae-oncology

Intent of 21.12

With the stationing of a Gynae-oncologist in hospital Kuala Lumpur, and by virtue of its location, it will be the main referral centre and treatment of female genital cancer. It is further blessed with the existence of all major subspecialties in the hospital, in particular being the availability of a specialized gynecological pathologist and a specialized gynaecology radiologist. As such the unit is suitably placed to be a center for Gynae-oncology fellowship training and gynae-oncology nurses training.

Measurable Elements of 21.12

The gynaecology unit will be a centre of excellence for training gynae-oncologist and oncology nurses.

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

21.13 RESEARCH RESPONSIBILITY**Standard**

Gynae Oncologist is responsible for research and audit.

Intent of 21.13

Gynae-oncologist is responsible for developing the Oncology databases for the purpose of research and audit. He is responsible for initiating research related to gynae oncology and their presentation in local or oversea conferences

Measurable elements of 21.13

1. The gynae-oncologist is responsible in developing the cancer database.
2. He is responsible for initiating research and their presentation at the right platform.

Evidence of continuous monitoring of above standards and remediable actions taken (Std: 100%)

21.14 STAFF-ROLES AND FUNCTIONS

21.14.1 Head of Gynae-Oncology unit

B) Administrative

1. To plan, implement and monitor the unit's activities according to the policies and procedure of the unit, the department, the hospital and the ministry of health Malaysia
2. To prepare the budget of the unit and be responsible for the effective use of the resources.
3. To implement and monitor quality assurance activities and ensure that remedial measures are taken if necessary.
4. To participate in the hospital's quality assurance activities.
5. To conduct regular meetings with unit personals.
6. To organize continuous medical educational activities for the department.
7. To audit the departments activities and performances and prepare its annual report for submission to the hospital director.
8. To conduct yearly assessment of all staff within the unit.

C) Clinical

1. To conduct assessment of the patients and plan a treatment for the patient.
2. To provide effective and efficient chemotherapy services.

3. To provide effective and efficient colposcopy services.
4. To lead the management of patients in the molar clinic.
5. To counsel patients on the nature of the disease, its sequels, the treatment options, complications and prognosis.
6. To lead the unit during surgeries.
7. To lead the unit at ward rounds.
8. To obtain the necessary consent for surgical intervention and blood transfusion.
9. To assist in palliation of patients.
10. To assist in the end of life care of the patient so as to ensure a dignified death.
11. To provide professional clinical leadership and supervision to the medical officers.
12. To undertake call duties as per roster
13. To provide professional clinical leadership and supervision to the specialist and medical officers.
14. To organize and undertake training of Fellows, masters students, medical officers and nurses.
15. To undertake call duties as per roster

16. To be up to date with the trends and development in gynae-oncology, and chemotherapy by keeping abreast of relevant literature conferences and courses.

21.14.2 Fellow in Gynae-Oncology / Specialist

A) Administrative

1. To assist the head of the unit in carrying out administrative duties.
2. To carry out non clinical duties as directed by the head of the unit, the head of department, or the hospital director.
3. To organize continuous medical education for the personals of the department
4. To attend talks, seminars, courses, and conferences to improve and update knowledge.
5. To plan and organize the tumor board meeting.
6. To participate in, and implement departments continuing medical education (CME) activities, morbidity and quality assurances (QA) activities, research projects, patient satisfaction studies, innovation and key performances indicators.
7. To assist in the organization of the departments courses.

B) Clinical

1. To conduct assessment of the patients and plan a treatment plan for the patient.

2. To provide effective efficient and professional chemotherapy services.
3. To assist the gynaecologist during the surgeries
4. To assist in the ward rounds.
5. To counsel patients on the nature of the disease, its sequels, the treatment options, complication of treatment, prognosis.
6. To obtain the necessary consent for surgical intervention and blood transfusion
7. To assist in palliation of patients
8. To assist in the end of life care of the patient so as to ensure a dignified death.
9. To provide professional clinical leadership and supervision to the medical officers
10. To undertake call duties as per roster
11. To be up to date with the trends and development in gynae-oncology, chemotherapy by keeping abreast of relevant literature conferences and courses.

21.14.3 Medical officer

1. To help the gynaecologist to review patient in the clinics
2. To help in the planning and organization of the tumor board meeting
3. To assist the surgeon in operative procedures.

4. To liaise with the radiotherapy department in planning radiotherapy treatment.
5. To assist in the molar clinic
6. To perform on call duties
7. To participate on a regular basis in the educational and audit programs within the department
8. To assist the ward rounds
9. To help in the organization of courses by the unit.
10. To help in counseling the patients in the various aspects.
11. To obtain consent for blood transfusion and surgical intervention.

21.14.4 Gynae oncology nurse

1. To assist in the day to day running of the various clinics
2. To assist the gynae-oncologist during examination of patients
3. To administer Day- care chemotherapy under supervision
4. To provide nursing care to the gynae-oncology patients
5. To trace laboratory investigations, previous hospitalization case notes, and radiological investigation

6. To document nursing report in the patients case notes
7. To attend to continuing nursing education (CNE) activities.
8. To counsel and update family members regarding the patient's condition.
9. To assist doctors in various procedures.
10. To receive referrals and register the patients.
11. To dispatch reply letters to referring sources.
12. To document, record, and perform data entry for statistical purposes
13. To contact patients when necessary
14. To draw blood for investigations.

22.0 MEDICATION MANAGEMENT AND USE

- 22.1 Medication use in the department complies with applicable laws and regulations of the Ministry of Health and hospital policy and is efficiently organized to meet patient needs.
- 22.2 An appropriately licensed pharmacist, technician, or other trained professional supervises the pharmacy or pharmaceutical use.
- 22.3 An appropriate selection of medications for prescribing or ordering is stocked and readily available.
- 22.4 Medications are properly and safely stored.
- 22.5 Emergency medications are available, monitored and safely stored.
- 22.6 Prescribing, ordering and transcribing are guided by the hospital policy.
- 22.7 Prescription needs to be complete and accurate.
- 22.8 Medication prescribed and administered are written in the patient's record.
- 22.9 A qualified individual are identified to administer medications.
- 22.10 Medication administration includes a process to verify the medication is correct based on the medication order.
- 22.11 Medication effects on patients are monitored.

22.12 Medication errors are reported in the time frame required

22.1 Standard

Medication use in the department complies with applicable laws and regulations of the Ministry of Health and hospital policy and is efficiently organized to meet patient needs

Intent of 22.1

1. Medication, as an important resource of patient care, must be organized effectively and efficiently
2. Medication management is not only the responsibility of the pharmaceutical services but also of managers and clinical care providers.
3. All medications shall be written using the chemical names and not the trade name (example Methyropa and not Aldomet).

Measurable element 22.1

1. A standard process is available on how medication use is organized and managed.
2. Appropriate sources of drug information are readily available to those involved in medication use.
3. All drugs and prescribed and utilized using chemical names

Compliance to practice standards (Std: 100%)

22.2 Standard by those individuals who are appointe

An appropriately licensed pharmacist, technician, or other trained professional supervises the pharmacy or pharmaceutical use.

Intent of 22.2

1. A qualified individual directly supervised the activities of the pharmacy or pharmaceutical service.
2. The individual is appropriately licensed, certified, and trained pharmacist.

Measurable elements 22.2

1. An appropriately licensed, certified and trained individual supervises all activities at the pharmacy.
2. All prescription are checked for appropriate chemical name, dose and duration.
3. List A drugs are appropriately countersigned .

Compliance to practice standards (Std: 100%)**22.3 Standard**

An appropriate selection of medications for prescribing or ordering is kept in stock and made readily available.

Intent of 22.3

1. Department has available medication for prescribing and ordering
2. Medication selection considers patient need and safety as well as economics.
3. The pharmacist shall notify prescribers of the shortage and suggested substitutes.
4. The pharmacist on a 3 monthly basis will inform the Head of Department and Head of Units regarding further request for drugs, budget and drugs not utilized.

Measurable elements of 22.3

1. Medications available for prescribing and ordering are appropriate to department's mission, patient needs and services provided.
2. There is list of medication available for the department.
3. There is a process to notify prescribers of the shortage and suggested substitutes.
4. All list A drugs countersigned by appropriate consultant

Compliance to practice standards (Std: 100%)

22.4 Standard

Medications are properly and safely stored

Intent of 22.4

1. Medications may be stored at patient care unit or wards.
2. Refer Guideline on Management of Drugs in the Ward : Pengendalian Ubat-ubatan di Wad
3. Ensure that all medications require a cold chain and are stored according to the requirements in the ward and clinic.

Measurable elements of 22.4

1. Medications are stored under conditions suitable for product stability
2. Controlled substances are accurately accounted for according to hospital policy.

3. Medications are accurately labelled with contents, expiration date and warnings.
4. All medication storage is periodically inspected by the pharmacist according to hospital policy to ensure medications are stored properly.

22.5 Standard

Emergency medications are available, monitored and safely stored

Intent of 22.5

1. In emergency situations, quick access to appropriate emergency medications is essential.
 - i. Emergency medications shall be kept in the emergency trolley
 - ii. The medications shall be checked by the staff nurse in charge in every shift to ensure availability and documented properly. The medications are replaced when used, damaged or out of date.

Measurable elements of 22.5

1. Emergency medications are available in the units and readily accessible to meet the emergency needs.
2. Emergency medications are monitored and replaced in a timely manner after use or when expired or damaged.
3. Documentation of who signed and verified the medications with changes made or noted on the medication expiry present in a log book.

Compliance to practice standards (Std: 100%)

Absence of expired drugs in the emergency trolley (Std: 100%)

22.6 Standard

Prescribing, ordering and transcribing are guided by the hospital policy

Intent of 22.6

1. Safe prescribing, ordering and transcribing are guided by the hospital policy.
2. Prescribing has to be in the chemical name of the drug.

Measurable elements of 22.6

1. Staff shall adhere to correct prescribing, ordering and transcribing practices

Compliance to practice standards (Std: 100%)

22.7 Standard

Prescription needs to be complete and accurate

Intent of 22.7

1. To improve patient safety, complete order of prescription required :
 - a. Patient's identification (name, IC no, RN)
 - b. The medication required (chemical name)
 - c. Frequency and duration of medication needed (od, bd, tds)
 - d. Prescription shall be signed clearly
2. Medication shall not be released by the pharmacy if there is incomplete, illegible or unclear medication order.

Measurable elements of 22.7

1. Medication order or prescriptions are complete and accurate.

Compliance to practice standards (Std: 100%)

Percentage of queried prescriptions (Std: < 5%)

22.8 Standard

Medication prescribed and administered are written in the patient's record

Intent of 22.8

The record of each patient who receives medications contains a list of medications prescribed or ordered for the patient and the dosage and times the medication was administered.

Measurable elements of 22.8

1. Medication prescribed or ordered are recorded for each patient in the notes.
2. Medication administration is recorded for each dose in the notes.
3. Medication information is kept in the patient's record or inserted into her records at discharge or transfer.

Compliance to practice standards (Std: 100%)

22.9 Standard

A qualified individual are identified to administer medications

Intent of 22.9

Administering a medication to treat patient requires specific knowledge and experience. In the department, all doctors, sisters and staff nurses are given this responsibility.

Measurable elements of 22.9

1. The identified individual responsible to administer medications does it appropriately at the specified time.

Compliance to practice standards (Std: 100%)

22.10 Standard

Medication administration includes a process to verify the medication is correct based on the medication order

Intent of 22.10

The safe administration of medication includes verifying the :-

- b. Medication with the prescription or order
- c. Time and frequency of administration with the prescription or order
- d. Dosage amount with the prescription or order
- e. Route of administration with the prescription or order
- f. Identity of the patient

Measurable elements of 22.10

1. Medications are verified with the prescription or order
2. The dosage amount of the medication is verified with the prescription or order
3. The route of administration is verified with the prescription or order
4. Medications are administered on a timely basis
5. Medications are administered as prescribed and noted in the patient's record.

Compliance to practice standards (Std: 100%)

22.11 Standard

Medication effects on patients are monitored

Intent of 22.11

1. The patient, his or her physician, nurse and other care providers work together to monitor patients on medications.
2. The purpose of monitoring is to evaluate the medication's effect on the patient's symptoms or illness.
3. Monitoring medication effects includes observing and documenting any adverse effects.

Measurable elements 22.11

1. Medication effects on the patients are monitored, including adverse effects
2. Adverse effects are documented in the patient's record
3. Adverse effects are reported in the time frame required to the pharmacy via the adverse drug reaction (ADR) format.

Compliance to practice standards (Std: 100%)

Audit on number of ADR

22.12 Standard

Medication errors are reported in the time frame required

Intent of 22.12

The medication errors shall be identified and reported using the Ministry of Health standardized form (Incident Reporting Form)

Measurable elements 22.12

1. Medication errors and near misses are reported in a timely manner

2. Medication errors and near misses reporting information is used to improve medication use processes.

Evidence of monitoring and remedial actions on medication errors (Std: 100%)

23.0 FOOD AND NUTRITION THERAPY

23.1 Standard

A variety of food choices, appropriate for the patient's nutritional status and consistent with his or her clinical care, are regularly available.

Intent of 23.1

Appropriate food and nutrition are important to patient's well being and recovery. In certain patients, the exact number of calories must be calculated and the appropriate food ordered accordingly to the calorie requirements of the patient.

Measurable elements 23.1

1. Food and nutrition, appropriate to the patient is regularly available
 2. All patients have an order of their food on record
 3. The food for the patient is based on the patient's nutritional needs and calorie requirements.
 4. The patient and family are educated about patient's dietary limitations.
- Compliance to practice standards (Std: 100%)

23.2 Standard

Food preparation, handling, storage and distribution are safe

Intent of 23.2

1. Food preparation, storage shall reduced the risk of contamination
2. Food shall distributed to patient at specified times.

3. Food and nutritional products, including enteral nutrition products, are available to meet special patient needs.

Measurable elements of 23.2

1. Food is prepared in a manner that reduces risk of contamination and spoilage
2. Food is stored in the manner that reduces risk of contamination and spoilage
3. Enteral nutrition products are stored according to manufacturer recommendation and hospital policy.
4. The distribution of food is timely.

23.3 Standard

Patient at nutrition risk receive nutrition therapy

Intent of 23.3

On initial assessment, patients are screened to identify those at nutritional risk. Patients are referred to a nutritionist for further assessment and a plan for nutrition therapy is carried out. The patient's progress is monitored and recorded in their record.

Measurable element of 23.3

1. Patient assessed at nutrition risk receive nutrition therapy
2. A collaborative process is used to plan, deliver and monitor nutrition therapy.
3. The patient's response to nutrition therapy is monitored and recorded in his or her records.

Compliance to practice standards (Std: 100%)

24.0 PAIN MANAGEMENT

24.1 Standard

Patients are supported in managing pain effectively

Intent of 24.1

1. Patient's pain needs to be assessed and managed appropriately.
2. Identify patient with pain during assessment and reassessment.
3. Providing management of pain according to availability of pain management services (e.g epidural in labour)
4. Communicating and educating patients and family about pain
5. Educating health care providers about pain and management

Measurable elements of 24.1

1. Based on the scope of services provided, patients in pain are assessed and managed.
2. Patients and family will be educated about pain, management and services available.
3. Based on the scope of services provided, the staff will educate about pain.

Compliance to practice standards (Std: 100%)

25.0 END OF LIFE

25.1 Standard

The department addresses end of life care.

Intent of 25.1

Patients who are in pain and dying have unique needs for respectful, compassionate care. All staff needs to be aware of the unique needs of patients in pain or at the end of life. Concern for the patient's comfort and dignity shall guide all aspects of care during the final stages of life.

Care shall include:

- a. Providing appropriate treatment for any symptoms according to the wishes of the patient and family.
- b. Sensitively addressing issues such as autopsy and organ donation
- c. Respecting the patient's values, religion and cultural preferences
- d. Involving the patient and family in all aspects of care
- e. Responding to the psychological, emotional, spiritual and cultural concerns of the patient and family.

Measurable elements of 25.1

1. Staffs are made aware of patient's unique needs at the end of life and those needs are documented.
2. End of life care provided by the organization addresses dying patients' needs.

Compliance to practice standards (Std: 100%)

25.2 Standard

Care of the dying patient optimizes his or her comfort and dignity

Intent of 25.2

The department shall ensure appropriate care of those in pain or dying:

- i. Manage their pain and primary or secondary symptoms
- ii. Prevent worsening of symptoms to the extent reasonably possible
- iii. Address patient and family psychological, emotional and spiritual needs regarding dying and grieving
- iv. Address patient and family religious and cultural concerns
- v. Involve the patient and family in care decisions.

Measurable elements of 25.2

1. Interventions are taken to manage pain and symptoms
2. Symptoms are prevented to the extent reasonable possible
3. Interventions to address the patient and family psychological, emotional and spiritual needs regarding dying and grieving
4. Interventions address patient and family religious and cultural concerns
5. The patient and family are involved in care decisions.

Compliance to practice standards (Std: 100%)

26.0 TRAINING AND EDUCATION

- 26.1 The department shall define the level of knowledge, skills and training requirements for all its personnel.
- 26.2 A written orientation programme shall be used to introduce new staff to the relevant aspects of the facilities and prepare them for their roles and responsibilities
- 26.3 The staff shall have access to appropriate educational programme to maintain and augment their professional competency. Participation in these educational or training activities shall be documented.
- 26.4 All staff is required to participate in the Ministry's e-CPD programme.
- 26.5 The department shall facilitate staff to attend relevant educational programmes conducted by professional groups, societies and educational institutes.

27.0 QUALITY AND RESEACH

27.1 Quality improvement

- 27.1.1 There shall be continuous process of collection and compilation of clinical data to establish the changing pattern of clinical practice, morbidity and mortality.
- 27.1.2 Whenever possible, these data shall be collected using a standard procedure of format throughout the Ministry of Health hospitals for the purpose of comparison and analysis.
- 27.1.3 There shall be a mechanism for audit findings to be used effectively for on going improvement of patient care.
- 27.1.4 To achieve of above objectives, the department shall participate in the following existing Ministry of Health quality initiatives:
- a. Incident reporting
 - b. Key performance indicators
 - c. Peri operative mortality review
 - d. National Indicators
 - e. Maternal mortality review
 - f. Perinatal mortality review
 - g. National audit
- 27.1.5 In addition to the above, the department shall also conduct hospital and department specific quality improvement studies and participate in clinical audits initiated at national level.

27.2 Research

- 27.2.2 The department shall work closely with the hospital Clinical Research Center and other relevant bodies such as universities and advance research activities
- 27.2.3 The department shall support research activities by providing funding, facilities and protected time for the staff.
- 27.2.4 The department shall participate in international multi centre clinical trials.

28.0 WHOLE HOSPITAL POLICY

28.1 The department of Obstetrics and Gynaecology comply with the Whole Hospital Policy in the following areas :-

- a. Hospital admission and discharge policy
- b. Visitors and visiting hours
- c. Policy on transportation service
- d. Infection control policy
- e. Sterilization service
- f. Management of waste products
- g. Policy on supply of pharmaceuticals and consumables
- h. Policy on acquisitions of assets and equipments
- i. Catering service
- j. Laundry and linen supply
- k. Cleaning service
- l. Engineering services including preventive and maintenance services
- m. Security services
- n. Fire precaution
- o. Medical record management
- p. Communication system
- q. Policy on quality assurance
- r. Occupational and Safety Health Assurance (OSHA)
- s. Policy regarding public relation, release of information and confidentiality

28.2 Specific infection control measures (Occupational Health Unit, Ministry of Health 2002) :-

- a. All staff shall observe proper hand hygiene at all times. There shall be adequate facilities to support this practice.

- b. Standard precaution measures shall be observed by all staff during patient care.
- c. Use of needle free devices shall be encouraged to prevent needle stick injuries. Needle stick injuries shall be reported and managed according to Ministry of Health guidelines.
- d. Patient with infectious disease shall be managed in accordance with the national infection control policy
- e. Staff shall observe policies and procedures when managing patients with infectious disease undergoing surgeries in OT
- f. Patients with infectious disease shall be managed in proper isolation rooms. There shall be adequate supply of personal protective equipments and consumables in managing these cases.

28.3 Disposal of clinical waste shall be in accordance with Ministry's policy and procedure on management of waste product. Sharps shall be disposed of in special impermeable yellow bins

APPENDIX

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Appendix 1 : TERMS OF REFERENCE FOR DEPARTMENT COMMITTEES

1) Transfusion committee

Standard

1. Supervision of incidence of transfusion errors and implementing corrective measures.
2. To reduce the C/T ratio in O&G department
3. To provide information and education to the departmental staff on issues related to transfusion.

Implications

1. To reduce the C/T ratio in O&G department.
2. Implementation of new protocol for GSH/GXM.

Frequency of meeting

Once in three months

2) Perinatal Mortality Committee

Standard

To improve antenatal care and also to reduce the perinatal mortality rate by auditing all perinatal deaths.

Roles and function

1. To ensure Ministry of Health perinatal mortality forms are filled for all perinatal deaths
2. To ensure appropriate investigations are performed to try and determine the cause of death
3. To audit all perinatal mortalities
4. To identify short falls in management of patients
5. To propose remedial measures

Meetings

Weekly audits are performed and presented during the department's morning briefing

Reports

An annual report is produced in January of the following year.

3) Maternal Mortality Committee

Standard

To improve medical care of pregnant women by auditing all maternal deaths

Role and function

1. To investigate all maternal deaths occurring in the hospital concerned.
2. To liaise with district health offices and other departments within the hospital who were involved with the management of patient

3. To complete the investigations and prepare a report for the national level inquiry.
4. To propose remedial measures to prevent further maternal mortalities
5. To present details of investigations at state meetings

Meetings

1. Hospital level meeting are carried out within 14 days of notification of maternal deaths.
2. The O&G medical officers who were involved in the management of the patient present the details of the patients care during the meeting.
3. All doctors involved in the management of the patient (including other departments) are invited to attend and present their point of view
4. The Head of O&G department provides guidance and consolidates all matters discussed during the meeting
5. The report is discussed at national level within 3 months.

Reports

A summary is produced in January of the following year for all maternal mortalities that occurred in the hospital with recommendations and published in the Annual departmental report.

4) Training Committee

Functions:

1. Plan activity/programmes for the O&G Department
2. Planned financial allocations and budget for training activity
3. To survey effectiveness of activity and ensure objectives are achieved
4. To ensure the achievement of target numbers for various categories of staff trained.

5) Risk management committee

Functions of the committee:

1. Conduct monthly meetings to track and trend plus analyze incidents that occur in the Department of Obstetrics and Gynaecology. The committee then provides a written report to the Head of Department and to senior staff members once a month.
2. The risk management committee is responsible for conducting “Root Cause Analysis” for incidents deemed to require it.
3. The risk management committee provides education to staff members in the form of case presentations and written documents about learning points from adverse incidents.

6) OSHA (Occupational Safety and Health Act 1994)

Objectives

1. To promote teamwork and discussions to improve safety and health at work place
2. To have forums and effective communications to facilitate ideas, opinions and feedbacks in issues related to safety and health
3. To cultivate interest and to motivate the staff in issues related to health and safety

Role and functions

1. To ensure the workplace is safe and is in accordance with the safety and health act
2. To have regular checks at work place (3 months once) to ensure safety and to identify possible hazards at work
3. To investigate, discuss and advise on measures to be implemented to ensure place of work is safe.
4. To organize programmes on safety and health
5. To collect and analyze statistics regarding accidents at work place.

Meetings

1. Once every 3 months

7) Continuing Professional Development committee (CPD)

Functions

1. To plan, promote, organize and monitor CPD activities in the department
2. The committee shall maintain the CPD records of its staff members and verify their attendance
3. The committee shall be chaired by a specialist. Its membership shall comprise of officers in charge of the various CPD activities for all categories of staff including doctors, nurses and medical assistants
4. The committee shall meet at least three times a year

8) Credentialing and Privileging Committee

Functions:

1. To review all credentialing and privileging activities in the Department relating to nurse, house officers, medical officers and specialists.
2. To review the credentialing and privileging criteria as determined by the Department Meetings: Once in three months

Appendix 2 : GUIDE ON PATIENT SAFETY IN THE WARD

1. As part of the department's initiative to enhance patient safety, attention shall be paid to team work, communication, education and training.
2. Correct identification of patient prior to surgery shall be done by two staff using 2 patient identifiers.
3. Patients shall be identified correctly prior to administration of blood and blood products, medications, procedures, interpretation of data, investigations and imaging.
4. Two staff shall counter-check the correct drug, dose, dilution and route prior to administration of high alert medications. Therapeutic levels shall be monitored where applicable.
5. Administration of blood and blood products shall adhere to the existing protocol.
6. The department shall undertake measures to prevent patient harm resulting from falls.
7. Patients in the operating theatre shall not be left unattended.
8. Adequate assistance shall be provided for positioning of the patient for any procedure.
9. Transport trolleys shall be fitted with side rails.

Appendix 3 : GUIDE ON SAFETY IN LABOUR ROOM

The objective is to ensure that mothers and babies admitted to the Labour Room get the optimum care and that deliveries are conducted in a safe environment in accordance to a structured guideline.

1. Labour Room staff shall check documents of patients on patients' arrival to the Labour Room.
2. All assessments and treatments of patients are to be documented in the patients' notes.
3. All deliveries are to follow the existing Labour Room protocols:
4. Normal vaginal deliveries.
5. Breech assisted deliveries
6. Instrumental deliveries
7. In the immediate post delivery period, while still in the Labour Room, the mother's vitals, temperature, uterine contractility and per vagina bleeding should be monitored closely. Any abnormalities are to be promptly informed to the doctor in charge.
8. All deliveries are to be recorded into the Delivery Registration Book which is in the Labour Room. Notes regarding the delivery are also recorded into the mother's file.

9. Mothers who are keen to take back the placenta will receive their placenta which is wrapped and given to them before they are transferred out of the Labour Room. If the mother declines the placenta, the placenta is to be kept in the deep freezer until disposed of by Radicare.
10. Transfer of mother and baby out of the Labour Room is with an assigned staff nurse and porter and the transfer procedure is to follow the hospital patient transfer protocol.

Appendix 4 : GUIDE ON MEDICATION SAFETY

1. The department shall abide by the rules and regulations of the Ministry of Health and hospital policy on medication use
2. All medication prescribed shall be in accordance with the approved list of drugs in the Ministry of Health.
3. Dedicated staff shall be responsible for the ordering and receiving of drugs to ensure adequate supply.
4. All medication shall be properly and safely stored.
5. Controlled substances shall be accurately accounted and recorded according to applicable law and regulation of the Ministry of Health.
6. All medications to be administered to the patients shall be accurately labeled with the name of medication and its concentration.
7. All medications and storage areas shall be periodically inspected according to hospital policy to prevent abuse, theft or loss. The process shall ensure that medication is stored properly and replaced when used, damaged or expired.
8. Inventory of medication shall preferably be kept in each storage area.
9. All medication administered to the patients shall be clearly written into the patients' records with regards to name (preferably generic), dosage, route and time.

10. Patient shall be monitored for drug effectiveness and adverse effects. All adverse effects shall be documented into the patients' records, informed later to the patient (or relatives) and reported to the pharmacy via the adverse drug reaction (ADR) format.
11. All medication errors and near misses shall be reported using the Ministry of Health standardized form (Critical Incident Form) for education and prevention as part of the patient safety program.

Appendix 5 : GUIDETO BABY SAFETY

1. Tagging process
 - a. Babies are to be tagged right after delivery and the tag should be kept on until delivery.
 - b. Tagging of the baby is be done in front of the mother and particulars on the tag are to be confirmed by the mother prior to being placed onto the baby.
 - c. Particulars on the tag are to include; baby of (mother's name), registration number (RN), date of birth, time of birth, gender of the baby.
 - d. Name tag should also be placed on stillborn babies.
2. The baby's birth is recorded in the following forms:
 - a. Birth Registration Form for “Jabatan Pendaftaran Negara” (JPN LM01)
 - b. Birth Certification Form for notification to the Health Department/ Health Clinic
 - c. 1st Feeding Chart Form
3. “Top-to-Tail” wash is done to the newborn infant. Mother is informed regarding administration of Hepatitis B vaccination and Vitamin K injection.

4. Staff will assist the mother to initiate early breastfeeding within the first hour of life before transferring mother and baby to the postnatal ward. Special care is taken as to positioning of the baby and how the baby is being held as to ensure the safety of the baby.
5. Prior to transfer to the postnatal ward and on arrival to the postnatal ward, both mother and baby's identity is verified using the following documents:
 - a. Baby's admission form
 - b. Mother's identification card or passport.
 - c. Antenatal card KIK 1(a)/96
 - d. Identification tag on mother and baby.
6. Throughout admission, mother and baby must keep tags on at all times.
7. All obstetrics wards that have postnatal patients with babies warded with mothers must follow the policies below:
 - a. The entrance to the ward must have locking capabilities and security personnel.
 - b. Mothers who are warded with their babies must inform the ward nurse before leaving babies unattended.
 - c. All forms of baby identification must only be signed by legal parents during discharge.
 - d. Baby tags must be checked by staff handling the discharge.

8. All babies that are discharged must go pass the security counter for safety inspection before allowing home.
9. All categories of staff are to be cautioned regarding any suspicious individuals.

Appendix 6 : LIST OF RECOMMEND EQUIPMENTS FOR VARIOUS FACILITIES

General ward Obstetrics

1. Nurse Responder Call Bell
2. Portable Scan
3. Portable Examination Couch
4. Wall Examination Light
5. Oxygen Flow Meter
6. Portable Suction Machine
7. CTG Machine
8. ECG Machine
9. Fetal Heart Detector
10. Dressing Trolley
11. Pulse Oxymeter
12. Medicine Fridge and Vaccine Fridge
13. Digital Weight Scale with Height
14. Digital Infant Weight Scale
15. Radiant Warmer
16. Resuscitation Trolley and Defibrillator
17. NIBP Monitor
18. Glucometer
19. Portable Incubator with Portable Oxygen
20. Electrical Breast Pump

General ward Gynaecology

1. Nurse Responder Call Bell
2. Ultrasound Scan Machine with the Transvaginal Probe
3. Portable Examination Couch

4. Wall Examination Light
5. Oxygen Flow Meter
6. Portable Suction Machine
7. ECG Machine
8. Dressing Trolley
9. Pulse Oxymeter
10. Medicine Fridge
11. Digital Weight Scale with Height
12. Radiant Warmer
13. Resuscitation Trolley, Cardiac Monitoring Device and Defibrillator
14. NIBP Monitor
15. Glucometer

High Dependency Ward

1. Equipments as in general ward
2. ICU Bed (Striker Bed)
3. Ripple Mattress
4. Warming Blanket
5. Physiological Monitoring Systems
6. Vacuum / oxygen outlet
7. Non Invasive Ventilator
8. Transport Monitor
9. Transport Ventilator, Transport Suction Device and Transport Trolley
10. Drug, Emergency Trolley and Defibrillator

Labour Ward

1. Delivery Bed
2. OT Examination Lamp

3. Cardiotocograph machines
4. Portable and Built-in Suction Machine
5. Oxygen Apparatus
6. Built-in Entonox (Nitrous oxide) Apparatus for Labour analgesia
7. Portable BP Monitoring Devices
8. Pulse Oxymeter Monitoring
9. Baby Warmer, Baby Resuscitation Bay with Oxygen Apparatus and Headbox
10. Vaccine Mini Fridge, Blood Fridge and Placenta Fridge
12. Weighing Scale
13. Somatometre
14. Emergency Trolley and Defibrillator
15. Vacum Extractor with the Suction System
16. Portable Ultrasound Machine Patient's Admission Center
17. Emergency Trolley and Transportation trolley
18. Digital Fetal Heart Detector
19. Oxygen Flow meter
20. Suction device
21. Glucometer device
22. Angle Poise Lamp for Examination
23. Infant Radiant Heater
24. Portable Incubator
25. Information Digital Screen
26. Pamphlet Stand and Health Education Room

Early Pregnancy Unit

1. Ultrasound Scan Machine with the Transvaginal Probe
3. Portable Examination Couch
4. Wall Examination Light
5. Oxygen Flow Meter

6. Portable Suction Machine
7. ECG Machine
8. Dressing Trolley
9. Pulse Oxymeter
10. Medicine Fridge
11. Digital Weight Scale with Height
12. Radiant Warmer
13. Resuscitation Trolley, Cardiac Monitoring Device and Defibrillator
14. NIBP Monitor

Gynaecology Unit

1. Portable examination couch
2. Angle poise lamp
3. Ultrasound machine with doppler and TVS probe
4. Bladder Ultrasound machine
5. Procedure Rooms
6. Colposcopy couch
7. Colposcopy machine with computer , printer & camera system
8. LEEP / LLETZ diathermy machine
9. Hysteroscopy couch
10. Hysteroscopy machine with computer , printer & camera system
11. Daycare Chemotherapy Lounge
12. Chemotherapy chairs
13. Fridge for chemotherapy drug
14. Counseling & Health Education Room

Urogynaecology Unit

1. Portable examination couch and angle poise lamp
2. Ultrasound machine with TVS probe

3. Bladder Ultrasound machine
4. Pad weighing machine
5. Cytoscope
6. Procedure Rooms
7. Urodynamic Study machine with computer for database & printer
8. Urodynamic Study machine couch
9. Cystoscopy machine - 0°, 30°, 70°
10. Patient toilet with uroflow
11. Counselling& Health Education Room

Maternal-fetal Unit

1. Portable examination couch
2. Ultrasound machines with computer for database
3. CTG machines
4. Procedure Rooms with ultrasound with computer, printer & camera system
5. Counselling& Health Education Room

Reproductive Medicine Unit

1. Treatment Room with procedure couch and Angel poise lamp
2. Ultrasound machine
3. Double Decker stainless steel trolley
4. Surgeon's stool
5. Counseling Room with computer, Flip chart stamp, TV and DVD player
6. Mastubatorium
7. Operation Theatre, with GA machine
8. Recovery Room
9. Portable vital sign monitor
10. Embryologist Office and Laboratory

11. Andrology Laboratory
12. Water Purification System
13. Vertical Laminar Flow
14. CO2 Incubator – Hereaus
15. Swing Out Centrifuge
16. Trinocular Phase contrast Microscope – Olympus/Nikon
17. TV Monitor with CCD Camera
18. Semen Quality Analyser
19. Heating Block
20. Makler Chamber
21. Haemocytometer /Naeubeur Chamber
22. Liquid Nitrogen Tank
23. Non Gas Oven
24. Planer Programmable controlled freezer
25. Trinocular Inverted microscope – Olympus / Nikon
26. Dissecting / Stereo Microscope with Warm Stage– Olympus / Nikon
27. Microscope Stage Warmer
28. Micromanipulator - Narishige
29. Vertical laminar Flow with K System Heating Stage
30. Fan Filter Unit with HEPA Filter
31. Transfer Variable Pipette
32. IR Sensor – CO2 Probe and Temperature Probe
33. pH Meter with Sensor Probe
34. Grant Block Heater
35. Cook/ Rocket Follicle Flushing Pump
36. Calibrated Rod and Surface Thermometers

Appendix 7 : GUIDE ON EFFECTIVE COMMUNICATION IN THE DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY

1. All categories of staff shall maintain effective interpersonal relationships with other staff members, patients and relatives.
2. The patient and/or family shall be given a full explanation of the procedure including its risks and benefits and other available alternatives. A written informed consent shall be obtained after the discussion.
3. The operating theatre counter/ labour room nurse/ reception nurse shall provide information on the patient to the family when required.
4. Intra and inter-department communication shall be open, honest and effective to ensure optimal patient care. Staff shall display respect and tolerance towards others to maintain harmonious interpersonal relationships.
5. All inter-departmental referrals shall be made after consultation with the specialist.
6. Medical officers shall inform the specialist of anticipated or unexpected problems (eg. postpartum haemorrhage, poor apgar score of baby)
7. Formal hand-over of patient information shall take place whenever it is necessary (eg. patients in maternity HDW, critically ill patient transferring to another unit, critically ill patients in ICU).

8. The head of department shall be consulted in the occurrence of any unexpected untoward event. The most senior category of staff on the team shall inform the patient/family of the incident in a caring, truthful and honest manner as soon as possible after a discussion with other healthcare providers. The head of department shall also inform the hospital director.

Appendix 8 : LIST OF MEDICATIONS USED IN OBSTETRICS & GYNAECOLOGY

A) List of drugs in Labour Room

1. Injection Adrenaline
2. Injection Aminophylline
3. Injection Adrenaline
4. Injection Aminophylline
5. Injection Amoxycillin+Clavulanic Acid
6. Injection Ampicillin
7. Injection Ampicillin +Sulbactam
8. Injection Atrophine Sulphate
9. Injection Cefoperazone
10. Injection Cefuroxime
11. Injection Chlorpheniramine Maleate
12. Injection Cimetidine
13. Injection Dexamethasone
14. Injection Dextrose 50%
15. Injection Frusemide
16. Injection Gentamycin Sulphate
17. Injection Heparin 5,000iu/ml
18. Injection Heparin 1,000iu/ml
19. Injection Heparined Saline
20. Injection Hydralazine
21. Injection Hydrocortisone
22. Injection Labetalol
23. Injection Lignocaine
24. Injection Magnesium Sulphate
25. Injection Metoclopramide

26. Injection Metronidazole
27. Injection Nalbuphine HCL
28. Injection Naloxone 0.02mg/ml
29. Injection Naloxone 0.4mg/ml
30. Injection Potassium Chloride
31. Injection Promethazine
32. Injection Sodium Bicarbonate
33. Injection Terbutaline Sulphate
34. Injection Vitamin K1 10mg/ml
35. Injection Vitamin K1 1mg/ml
36. Injection Vitamin K1 2mg
37. Modified Fluid Gelatin 4%
38. Water for injection

B) List of drugs in Labour Room (Fridge Items and Vaccine)

1. Actrapid HM 1,000iu
2. Injection Carbroprost Tromethamine
3. Injection Hepatitis B Vaccine
4. Injection Hepatitis Immunoglobulin
5. Injection Oxytocin
6. Injection Oxytocin+Ergometrine

C) List of drugs in Labour Room (Inhalation Solution)

1. Ipratropium Bromide
2. Salbutamol Sulphate Solution
3. Terbutaline Sulphate Solution

D) List of drugs in MOT

1. Injection Adrenaline
2. Injection Aminophylline
3. Injection Amoxycillin+Clavulanic Acid
4. Injection Ampicillin
5. Injection Ampicillin +Sulbactam
6. Injection Atrophine Sulphate
7. Injection Bupivacaine HCL 5mg/ml
8. Injection Bupivacaine HCL 5mg/ml + Dextrose Monohydrate 80mg/ml
9. Injection Cefoperazone
10. Injection Calcium Gluconate 10%
11. Injection Chlorpheniramine Maleate
12. Injection Cimetidine
13. Injection Dextrose 50%
14. Injection Ephedrine HCL
15. Injection Frusemide
16. Injection Gentamycin Sulphate
17. Injection Heparin 1,000iu/ml
18. Injection Heparined Saline
19. Injection Hydralazine
20. Injection Hydrocortisone
21. Injection Ketorolac Trometamol
22. Injection Labetalol
23. Injection Lignocaine
24. Injection Magnesium Sulphate
25. Injection Metoclopramide
26. Injection Nalbuphine HCL
27. Injection Naloxone 0.02mg/ml
28. Injection Naloxone 0.4mg/ml
29. Injection Neostigmine

30. Injection Ondansetron
31. Injection Sodium Bicarbonate
32. Injection Sodium Chloride
33. Injection Terbutaline Sulphate
34. Injection Thiopental Sodium
35. Injection Vitamin K1 10mg/ml
36. Injection Tramadol
37. Modified Fluid Gelatin 4%
38. Water for injection

E) List of drugs in MOT (Fridge Items)

1. Injection Atracurium
2. Injection Carbroprost Tromethamine
3. Injection Oxytocin
4. Injection Propofol
5. Injection Suxamethonium
6. Injection Vecuronium

F) List of drugs in MOT (Inhalation Solution)

1. Ipratropium Bromide
2. Salbutamol Sulphate
3. Terbutaline Sulphate

G) List of drugs in HDW

1. Injection Adrenaline
2. Injection Amoxycillin + Clavulanic Acid
3. Injection Ampicillin
4. Injection Ampicillin + Sulbactam

5. Injection Atrophine Sulphate
6. Injection Cefoperazone
7. Injection Cefuroxime
8. Injection Chlorpheniramine Maleate
9. Injection Cimetidine
10. Injection Crystal Penicillin 1 Mega
11. Injection Dexamethasone
12. Injection Dextrose 50%
13. Injection Ephedrine HCL
14. Injection Frusemide
15. Injection Gentamycin Sulphate
16. Injection Heparin 1,000iu/ml
17. Injection Heparin 5,000iu/ml
18. Injection Heparined Saline
19. Injection Hydralazine 14
20. Injection Hydrocortisone
21. Injection Hyoscine
22. Injection Labetalol
23. Injection Lignocaine
24. Injection Magnesium Sulphate
25. Injection Metoclopramide
26. Injection Metronidazole
27. Injection Potassium Chloride
28. Injection Promethazine
29. Injection Sodium Bicarbonate
30. Injection Sodium Chloride
31. Injection Terbutaline Sulphate
32. Modified Fluid Gelatin 4%
33. Water for injection

H) List of drugs in HDW (Fridge Items)

1. Injection Carboprost Tromethamine
2. Injection Oxytocin
3. Injection Oxytocin + Ergometrine

I) Lists of drugs in HDW (Inhalation Solution)

1. Ipratropium Bromide
2. Salbutamol sulphate
3. Terbutaline Sulphate

J) List of drugs in Obstetrics wards

1. Injection Adrenaline
2. Injection Ampicillin
3. Injection Ampicillin+Sulbactam
4. Injection Atrophine Sulphate
5. Injection Chlorpheniramine
6. Injection Cimetidine
7. Injection Crystal Penicillin
8. Injection Dextrose 50%
9. Injection Ephedrine
10. Injection Frusemide
11. Injection Gentamycin
12. Injection Heparin 1,000iu
13. Injection Heparin 5,000iu
14. Injection Heparinised Saline
15. Injection Hydrocortisone

16. Injection Hyoscine Butylbromide
17. Injection Labetalol HCL
18. Injection Lignocaine
19. Injection Magnesium Sulphate
20. Injection Metoclopramide
21. Modified Fluid Gelatin 4%
22. Injection Potassium Chloride
23. Injection Promethazine
24. Injection Sodium Bicarbonate
25. Injection Sodium Chloride
26. Injection Terbutaline Sulphate
27. Water For Injection

K) List of drugs in Obstetric Wards (Fridge Items and Vaccine)

1. Injection Oxytocin
2. Injection Oxytocin+Ergometrine
3. Injection BCG (Only keep in MH4B)

L) List of drugs in Obstetric Wards (Inhalation Solution)

1. Ipratropium Bromide
2. Salbutamol Sulphate Solution
3. Terbutaline Sulphate Solution

M) List of drugs (Tablet)

1. Acetylsalicylic Acid 300mg
2. Ascorbic Acid 50mg
3. Bacampicillin 400mg

4. Bisacodyl 5mg
5. Bromhexine 8mg
6. Calcium lactate 300mg
7. Chlorpheniramine 4mg
8. Cimetidine 200mg
9. Cloxacillin 250mg
10. Diclofenac Sodium 50mg
11. Dinoprostone Vaginal Tablet (Fridge Item)
12. Diphenoxylate HCL 2.5mg + Atropine Sulphate 25µg
13. Erythromycin 400mg
14. Ferrous Fumarate 200mg
15. Folic Acid 5mg
16. Frusemide 40mg
17. Gemeprost Suppository (Fridge Item)
18. Hyoscine 10mg
19. Labetalol 100mg
20. Magnesium Trisilicate
21. Mefenamic Acid 250mg
22. Methyl dopa 250mg
23. Metoclopramide 10mg
24. Nifedipine 10mg
25. Papase 10,000 iu
26. Paracetamol 500mg
27. Potassium Chloride 600mg
28. Prochlorperazine 5mg
29. Tripolidine HCL 0.25mg+Pseudoephedrine HCL 60mg
30. Vitamin B complex

N) List of drugs for Emergency Trolley

1. Injection Adenosine
2. Injection Adrenaline
3. Injection Amiodarone
4. Injection Atropine Sulphate
5. Injection Calcium Chloride 1G/ Injection Calcium Gluconate 1G
6. Injection Dextrose 50%
7. Injection Flumazenil
8. Injection Hydrocortisone
9. Injection Isoprenaline
10. Injection Lignocaine
11. Injection Naloxone
12. Injection Neostigmine
13. Injection Orphenadrine Citrate
14. Injection Sodium Bicarbonate 8.4%
15. Injection Verapamil
16. Water For Injection

O) List of drugs for Gynae-Oncology

1. Injection Actinomycin D
2. Injection Bleomycine
3. Injection Carboplatin
4. Injection Cisplatin
5. Injection Cyclophosphamide
6. Injection Dexamethasone
7. Injection Etoposide
8. Injection Filgrastim
9. Injection Folinic Acid
10. Injection Gemcitabine

11. Injection Granisetron
12. Injection Methotrexate
13. Injection Metoclopramide
14. Injection Paclitaxel
15. Injection Vincristine

P) List of drugs for Infertility

1. Injection Follitropin Beta
2. Injection Follitropin Alfa
3. Injection Human Chorionic Gonadotrophin
4. Progesterone Gel 8%
5. Tablet Clomiphene Citrate

Q) List of drugs for Menopause

1. Conjugated Estrogen 0.3mg
2. Conjugated Estrogen 0.625mg
3. Conjugated Estrogen 0.625mg+Medroxyprogesterone Acetate 2.5mg (Premelle 2.5)
4. Conjugated Estrogen Cream
5. Estradiol 1mg&Estradiol 1mg+Dydrogesterone 10mg (Femoston 1/10)
6. Estradiol 1mg+Norethisterone Acetate 0.5mg (Activelle)
7. Estradiol Valerate 1mg
8. Estradiol Valerate 2mg&Estradiol 2mg+Norgestrel 0.5mg (Progyluton)
9. Tibolone 2.5mg

R) List of drugs and non drugs for Contraception

2. Ethinyl Estradiol 30mcg+Desogestrel 150mcg (Marvelon)
3. Ethinyl Estradiol 30mcg+Levonorgestrel 150mcg (Rigevidon)
4. Ethinyl Estradiol 35mcg+Cyproterone Acetate 2mg (Diane 35)
5. Injection Medroxyprogesterone Acetate 150mg (Depo-Provera)
6. Levonorgestrel 20mcg/24H (Mirena)
7. Norethisterone 350mcg (Noriday)
8. Condom
9. Copper 250-cu 250 (Multiload)

S) List of drugs for General Gynecology

2. Clotrimoxazole Pessary
3. Danazol
4. Dydrogesterone
5. Goserelin
6. Leuprolide Acetate
7. Medroxyprogesterone Acetate
8. Mefenamic Acid
9. Tolterodine
10. Tranexamic Acid

T) List of drugs for osteoporosis

1. Alendronate 70mg+Cholecalciferol 70mcg (Fosamax Plus)

Appendix 9 : STAFF ROLES AND FUNCTIONS

A. MEDICAL OFFICER

General procedures

- Setting up peripheral intravenous line
- Arterial blood gases
- Urinary catheterization

Obstetrics

- Artificial rupture of membrane
- Conduct of normal vaginal deliveries
- Conduct of vaginal twin deliveries
- Episiotomy wound repair
- Ultrasound Scanning Level I (Obstetrics Evaluation)

Gynecology

- Evacuation of retained Products of Conception (ERPOC)
- Suction and Curettage
- Dilatation and Curettage
- Pap Smear
- Endometrial sampling procedure
- Bilateral Tubal Ligation
- Marsupialization of Bartholin's Cyst
- Secondary Suturing of wound breakdowns
- Insertion and removal of IUCD
- Insertion and removal of Ring Pessary
- Ultrasound Scanning Level I (Gynecology Evaluation)

B. SPECIALIST AND CONSULTANT**Obstetrics**

- Vaginal delivery of twin pregnancy
- Breech delivery
- Vacuum delivery
- Forceps delivery
- Complicated Caesarean Section, Hysterectomy, Hysterostomy
- B-Lynch and Internal Iliac Artery Ligation
- Cervical Cerclage
- Manual Removal of Placenta
- Replacement of uterine inversion
- Management of Shoulder Dystocia
- Repair of extended / third degree perineal tear
- Repair of ruptured uterus
- External Cephalic Version
- Level II Ultrasound examination
- Amniocentesis under Ultrasound Guidance

Gynecology

- Suction and Curettage
- Colposcopic examination and procedure
- Cone biopsy / LLETZ / Electro diathermy
- Anterior Colporrhaphy
- Posterior Colpoperineorrhaphy
- Vaginal hysterectomy
- Abdominal hysterectomy
- Myomectomy
- Oophorectomy
- Omentectomy

- Ovarian Cystectomy
- Bilateral Tubal Ligation
- Laparoscopic – diagnostic, therapeutic (salpingectomy, cystectomy), adhesiolysis, salpingolysis, ovarian drilling
- Cystoscopy
- Hysteroscopic – diagnostic
- Intrauterine insemination
- Ultrasound examination – abdominal, transvaginal (including follicular tracking)

C. STAFF NURSES

(i) Midwifery Nurses

A. MIDWIFERY NURSE IN PAC

Nursing Care

1. Accepting cases.
2. Attend to emergency cases and initiate 'Red Alert'.
3. Take history.
4. Take vital sign and basic measurement.
5. Check for urine albumin and glucose.
6. Do cardiotocograph if ordered.
7. Carryout doctors order.
8. Administration of drugs as ordered by the doctor.
9. Conduct delivery if fetal head on perineum.
10. Refer to the Pediatric team if the baby requires to be seen by Pediatric doctor or require resuscitation.
11. Preparation of patient for surgery if the patient needs to has an emergency surgery.

12. Documentation of care and treatment rendered to the patient into patient's medical report.
13. Registration of cases in the registration book.
14. Ensure that patients are sent to the correct ward.

Management

1. Ensure the environment of the ward is clean and safe for the patient and workers.
2. Ensure sufficient staff to work at all time.
3. Supervise and do routine check on dangerous drugs, emergency trolley and infection control.
4. Supervise in usage of government assets.
5. Keep tract on the monthly census and statistic.

Assisting Doctor

1. Assist doctor in neonatal resuscitation.
2. Assist doctor in resuscitation of patient during 'Red Alert'

Lab specimen

1. Ensure blood specimens are taken as ordered.
2. Ensure all specimens are sent to the lab.

Supervision

1. Student Midwives
2. Medical Student

3. Basic Student

B. MIDWIFERY NURSE IN LABOUR WARD

Nursing Care

1. Accepting cases from the wards for delivery.
2. Taking vital sign for patient in labor including doing cardiotocograph.
3. Follow doctors' round and involve in management of patient.
4. Carryout doctors order.
5. Care for patient:
 - 5.1 General:-
 - On augmentation
 - On tocolysis
 - On blood transfusion
 - On insulin sliding scale.
 - On intravenous antihypertensive drugs
 - 1st stage of labor
 - post delivery
 - 5.2 Care for high risk pregnancy such as heart disease, pre-eclampsia etc.
6. Administration of drugs as ordered by the doctor.
7. Conduct normal delivery.
8. Performed top and tail for baby.
9. Performed initial assessment for the baby.
10. Administering vaccine to the baby.
11. Refer to the Pediatric team if the baby requires to be seen by Pediatric doctor or require resuscitation.
12. Preparation of patient for surgery.
13. Documentation of care and treatment rendered to the patient into patient's medical report.

14. Registration of delivered cases in the birth registries.
15. Help patient in initiation of breast feeding.

Management

1. Ensure the environment of the ward is clean and safe for the patient and workers.
2. Ensure sufficient staff to work at all time.
3. Supervise and do routine check on dangerous drugs, emergency trolley, incubator, vaccine fridge's temperature, blood fridge's temperature, incubator and infection control.
4. Supervise in usage of government assets.
5. Encourage father friendly policy.
6. Keep tract on the monthly census and statistic.

Assisting Doctor

1. Assist doctor in neonatal resuscitation.
2. Assist doctor in resuscitation of patient during 'Red Alert'

Lab specimen

1. Ensure blood specimens are taken as ordered.
2. Ensure all specimens are sent to the lab.
3. Ensure all results are back and shown to the doctor.

Health Teaching

1. Health teaching will be given to individual patient.

Supervision

1. Student Midwives
2. Medical Student
3. Basic Student

C. MIDWIFERY NURSE IN THE WARD

Nursing Care

1. Accepting cases from PAC.
2. Tagging of patient and registration in the ward's registration book.
3. Orientation of patient according to the Standard of Procedure.
4. Taking patient's vital sign, timing of contraction and the fetal's heart rate.
5. Do cardiotocograph as ordered.
6. Carryout doctor's order.
7. Sent patient to Labour Ward if patient go into active phase of labour.
8. Preparation of patient for surgery.
9. Care for patient post delivery.
10. Care for patient post surgery.
11. Follow doctors' round and involve in management of patient.
12. Help patient to breast feed her baby.
13. Administration of drugs as ordered by doctor.
14. Perform top and tail for the baby.
15. Care for baby under phototherapy.
16. Refer to the Pediatric team if the baby requires to be seen by the Pediatric doctor.

Management

1. Ensure the environment of the ward is clean and safe for the patient and workers.
2. Ensure sufficient staff to work at all time.
3. Supervise and do routine check on dangerous drugs, emergency trolley and infection control.
4. Supervise in usage of government assets.
5. Encourage breast feeding policy.
6. Keep tract on the monthly census and statistic.

Assisting Doctor

1. Assist doctor in neonatal resuscitation.
2. Assist doctor in resuscitation of patient during 'Red Alert'
3. Assist Pediatric Team during round and blood taking.

Lab specimen

1. Ensure blood specimens are taken as ordered.
4. Ensure all specimens are sent to the lab.
5. Ensure all results are back and shown to the doctor.

Health Teaching

1. Health teaching will be given to patient on:-
 - Breast feeding
 - Care of episiotomy wound
 - Immunization
 - Family planning

Supervision

Student Midwives

Medical Students

Basic Students

(ii) Subspecialty nurses

A. GYNAE – ONCOLOGY UNIT

Administration of clinic

1. Tracing record from the record office before each clinic session.
2. Ensure patient's record is updated with patient's lab results and radiology's finding before each clinic's session.
3. Record patient's attendance during clinic's session.
4. History taking.
5. Tracing of defaulter and patient with abnormal result.
6. Getting appointment date for all referrals to other department.
7. Dispatching of patient's medical record to the record office after each clinic session.
8. Keep tract on the monthly census and statistic for the clinic.
9. Arrange patient for preoperative investigation such as CXR, ECG and blood investigation.
10. Arrange patient for operation.
11. Preparation of patient's record for the monthly "Tumour Board Meeting".

Nursing Care

1. Taking vital sign during:
 - Clinic session
 - Administration of cytotoxic drugs
 - After procedure
2. Observe for bleeding after procedure such as colposcopy and biopsy

Assisting doctor

1. Assisting doctor during procedure such as colposcopy, hysteroscopy biopsy.
2. Assisting and carryout orders during clinic session.

Lab specimen

1. Taking blood specimen as ordered.
2. Ensure all specimens are sent to the lab.

Counselling

1. Become part of the counselling team during family conference to break the news.

Administration of cytotoxic drugs.

1. Indenting cytotoxic drugs as prescribed by doctor.
2. Administration of cytotoxic drugs to the patient.
3. Knowledgeable in the do's and don'ts during administration of cytotoxic drug.

Health Teaching

1. Inform patient regarding the cytotoxic drug's side effects and how to overcome or reduce the side effects.
2. The importance of continuing the treatment.

B. REPRODUCTIVE UNIT

Administration of clinic

1. Accepting referral cases and cases by appointment.
2. Registered all the cases that attended the clinic.
3. History taking from patient and her spouse.
4. Giving appointment for trans vaginal scan via phone and appointment for next review.
5. Ensure patient's record is updated with patient's lab results and radiology's finding before each clinic's session.
6. Arrange for HisteroSalphingoGraphy
7. Arrange for the admission of patient who requires to undergoing procedure.
8. Dispatching of patient's medical record to the record office after each clinic session.
9. Keep tract on the monthly census and statistic for the clinic.
10. Ensure preparation of patient undergoing Assisted Reproductive Technique as per protocol.

Nursing Care

1. Taking vital sign every clinic session and during procedure.
2. Preparation of patient who needs to undergo surgery.
3. Doing observation for patient in the recovery.

4. Care for patient under sedation.
5. Ensure the day care surgical theatre is clean after every procedure.
6. Administering hormone injection as ordered.

Assisting doctor

1. Assist doctor during consultation clinic day.
2. Assist doctor during procedure such as Intrauterine Insemination, oocyte retrieval and embryo transfer.
3. Assist doctor in follicle tracking.

Lab specimen

1. Taking blood specimen as ordered.
2. Taking PAP Smear
3. Ensure all specimens are sent to the lab
4. Trace all result

Counselling

1. Counselling will be given regarding the possible courses of infertility, the investigation required, the chances of pregnancy and the available treatment for them.
2. Counselling regarding the treatment, drugs used and the side effects.
3. Counselling for Artificial Reproductive Technique.

Health Teaching

1. Teaching the patient in self administration of the hormone injection

C. UROGYNAECOLOGY UNIT

Administration of clinic

1. Tracing record from the record office before each clinic session.
2. Ensure patient's record is updated with patient's lab results before each clinic's session.
3. Record patient's attendance during clinic's session.
4. History taking.
5. Tracing of defaulter and patient with abnormal result.
6. Getting appointment date for all referrals to other department.
7. Dispatching of patient's medical record to the record office after each clinic session.
8. Keep tract on the monthly census and statistic for the clinic.
9. Arrange patient for preoperative investigation such as CXR, ECG and blood investigation.
10. Arrange patient for operation.

Nursing Care

1. Taking vital sign during every clinic session and during procedure.

Assisting doctor

1. Assisting doctor during procedure.
2. Assisting and carryout orders during clinic session.

Lab specimen

1. Taking blood specimen as ordered.

2. Ensure all specimens are sent to the lab.

Counselling to patient

1. Counselling regarding patient's condition, treatment, drugs used and the side effects.

Procedure

1. Carryout Urodynamic Study.
2. Carryout bladder Scan and report the result to the doctor.
3. Carryout DMSO via Intravesical.

Health Teaching

1. Patient will be taught how to do 'clean intermittent self catheterization' and the care of catheter.
2. Teaching regarding how to do bladder diary.
3. Post operative care such as perineal care to prevent infection.

D. MATERNAL FETO MEDICINE UNIT

Administration of clinic

1. Tracing record from the record office before each clinic session.
2. Ensure patient's record is updated with patient's lab results before each clinic's session.
3. Record patient's attendance during clinic's session.
4. History taking.
5. Tracing of defaulter and patient with abnormal result.

6. Getting appointment date for all referrals to other department.
7. Dispatching of patient's medical record to the record office after each clinic session.
8. Keep track on the monthly census and statistic for the clinic.

Nursing Care

1. Taking vital sign for all patient fetal heart rate for antenatal cases.
2. Doing Cardiotocograph for antenatal cases.

Assisting doctor during procedures

1. Amniocentesis
2. Fetal pleural tap
3. Fetal bladder tap
4. Amnioreduction.
5. In-utero blood transfusion
6. Fetal blood sampling
7. Chorionic villus sampling
8. Fetal skin biopsy

Lab specimen

1. Taking blood specimen as ordered.
2. Ensure all specimens are sent to the lab.

Counselling to patient

1. Bereavement counselling
2. Fetal anomaly pre test

3. Fetal anomaly post test
4. Pre pregnancy
5. Pre and post delivery in the ward.

Preparation of courses

1. Prepare Basic Ultrasound and Advance Ultrasound courses for government and non-government doctors.

Coordinating Meeting with Other Department

1. Coordinate with the Paediatrics Department in having Perinatal Service Unit's meeting every week.

Appendix 10 : RECOMMENDED BASIC TRAINING REQUIREMENTS OF STAFF

A) PROCEDURES FOR MEDICAL OFFICERS THAT NEED PRIVILEGING BY USING LOG BOOK

1. Instrumental vaginal deliveries
 - a. Ventouse delivery
 - b. Forceps delivery
2. Caesarian Section
 - a. Lower segment caesarian section
 - b. Classical caesarian section
3. External Cephalic Version
4. Manual Removal of Placenta
5. Diagnostic Hysteroscopy
6. Laparoscopy
 - a. Level I: Diagnostic, Laparoscopic and Dye
 - b. Level II: Salpingectomy, Cystectomy
7. Laparotomy
8. Suction and Curettage of molar pregnancy
9. Central intravenous line insertion
10. Cervical Cerclage

B) PROCEDURES THAT NEED PRIVILEGING FOR SPECIALISTS (GENERALIST)

1. Laparoscopy
 - a. Level III: LAVH
 - b. Level IV: TLH, Burch Colposuspension and Myomectomy
2. Tension Free Vaginal Tape; Tension Free Vaginal Tape-Obturator

3. Sacrospinous Fixation
4. Sacrocolpoplexy
5. Wertheim's Hysterectomy
6. Pelvic Lymph Node Clearance
7. Laparoscopic Pelvic Lymphadenectomy
8. Laser gynaecologic procedures
9. Conduct of assisted reproduction
10. Ultrasound scanning Level 3
11. Amniocentesis

C) LIST OF ALL PROCEDURES THAT SUBSPECIALISTS CAN PERFORM WITHOUT ADDITIONAL TRAINING

1. FETO-MATERNAL MEDICINE

- i. Ultrasound scanning Level III
- ii. Amniocentesis and Fetal Blood Sampling
- iii. Cordocentesis
- iv. Amnioreduction
- v. Amnioinfusion
- vi. Bladder Tapping
- vii. Pleural Tapping
- viii. Shunt Replacement
 - a. Bladder
 - b. Pleural
- ix. Septostomy
- x. Lower Segment Caesarian Section < 32 week
- xi. Lower Segment Caesarian Section with Post Partum Hemorrhage
 - a. Internal Iliac Ligation
 - b. B Lynch Suturing

2. REPRODUCTIVE MEDICINE

- i. Intrauterine Insemination (IUI)
- ii. Ovum Pick Up
- iii. Embryo Transfer
- iv. Ovum-Csyd Aspiration
- v. Follicular Tracking
- vi. Open Testicular Epididymal Seminal Aspiration (TESA) / Extraction (TESG)
- vii. Percutaneous Epididymal Seminal Aspiration (PESA)
- viii. Minimally Invasive Surgery – Level IV
- ix. Laparoscopic Cystectomy / Neosalpingectomy / Reversal of Tubal Ligation
- x. Laparoscopic Myomectomy – level IV
- xi. Total Laparoscopic Hysterectomy (TLH) – Level IV
- xii. Sono-Hysteroimage
- xiii. Hysteroscopy
 - a. Level I: Diagnostic
 - b. Level II: Minor procedures; Endometrial biopsy, Polyp excision and excision of septum, synechia
 - c. Level III: Major procedures; TCRE, TCRM

3. GYNAE-ONCOLOGY

Preinvasive Diseases of Female Genital Tracts Procedures

- i. Colposcopy +/- Biopsy; LLETZ / LEEP / Knife Cone Biopsy
- ii. Hysteroscopy +/- Biopsy
 - a. General Anaesthesia
 - b. Outpatient

Invasive Diseases of female Genital Tracts Procedures

- i. Radical Hysterectomy +/- Pelvic Lymph Node Dissection
- ii. Staging and Debulking Laparotomy +/- Appendicectomy +/- Omentectomy +/- Pelvic Lymph Node Clearance
- iii. Total Abdominal Hysterectomy and Bilateral Salpingo-oophorectomy +/- Pelvic Lymph Node Clearance +/- Para-aortic Lymph Node Dissection
- iv. Simple Vulvectomy
- v. Radical Vulvectomy +/- Bilateral Groin Lymph Node Dissection
- vi. Wide Local Excision
- vii. Anterior Exenteration
- viii. Posterior Exenteration
- ix. Total Exenteration

4. URO-GYNAECOLOGY

- i. Urodynamic Studies (UDS)
- ii. Cystoscopy
- iii. Bladder Ultrasound
- iv. Vaginal Hysterectomy
- v. Pelvic Floor Repair
- vi. Sacrospinous Fixation
- vii. Tension Free Vaginal Tape – Obturator
- viii. Anterior Repair +/- Mesh
- ix. Posterior Repair +/- Mesh
- x. Anal Incontinence Surgery
- xi. Suburethral Sling
 - a. Transobturator
 - b. Retropelvic

- xii. Sacrocolpoplexy
- xiii. Burch Colposuspension
- xiv. Fourth Degree and Extended Tears
- xv. Manchester Repair- Amputation of Cervix and Shortening of Cardinal Ligaments

5. ADVANCED O&G

- i. Management of High Risk Pregnancy
- ii. Caesarian Hysterectomy
- iii. Internal Iliac Ligation
- iv. B-Lynch Suturing
- v. Third Degree Tears
- vi. CVS
- vii. Amniocentesis
- viii. Amnioinfusion / Amnioreduction
- ix. Cordocentesis
- x. Anomaly Screen / Detailed Scan
- xi. Laparoscopic Surgery
 - a. Ectopic surgery (Salpingectomy)
 - b. Ovarian Cystectomy
 - c. Moderate severe Adhesiolysis
 - d. PCO Ovarian Drilling
- xii. Hysteroscopic Surgery
 - a. Level I: Diagnostic
 - b. Level II: Endometrial biopsy, Polyp excision and Excision of septum, synechia
- xiii. Follicular Tracking
- xiv. Minimally Invasive Surgery – Level 3

- xv. Preinvasive Diseases of Female Genital Tracts Procedures
 - a. Colposcopy +/- Biopsy; LLETZ / LEEP / Knife Cone Biopsy
 - b. Hysteroscopy +/- Biopsy
- xvi. Urodynamic Studies (UDS)
- xvii. Cystoscopy
- xviii. Bladder Ultrasound
- xix. Vaginal Hysterectomy
- xx. Pelvic Floor Repair
- xxi. Tension Free Vaginal Tape – Obturator
- xxii. Anterior Repair +/- Mesh
- xxiii. Posterior Repair +/- Mesh
- xvi. Suburethral Sling
 - a. Transobturator
 - b. Retropelvic
- xvii. Manchester Repair - Amputation of Cervix and Shortening of Cardinal Ligaments

Appendix 11 : KEY PERFORMANCE INDICATORS

Table II – Key performance indicators for quality and safety

Aspect or performance : Quality & Safety		
Key performance indicators		
Dimension : Patient focused care		Optimal target/ standard
1	Waiting time to see doctor at Gynaecology Specialist Clinic	>90% are seen within 30 minutes
Dimension : Clinical effectiveness and risk management		
2	Incidence of massive post partum heamorrhage (PPH)	Not more then 0.5% of total deliveries
3	Occurrence of urinary tract injury following hysterectomy	No cases (sentinel event)
4	Timeliness in surgery for Very urgent case: Caesarean section	>95% of cases undergo caesarean section within 30 minutes of diagnosis
5	Average frequency of departmental morbidity or mortality audit	At least 6 times in 6 months

Table III : Key performance indicators for productivity

Aspect or performance : Productivity		
Key performance indicators		
Dimension : Workload		Optimal target/standard
6	Average number of out-patients seen by each specialist per month	At least 50 cases per month

Appendix 12 : NATIONAL INDICATOR APPROACH

Table IV: National indicator approach

National indicator approach		
Effectiveness and efficiency		Optimal target/standard
1	Incidence of massive post partum heamorrhage (PPH)	Not more then 0.5% of total deliveries
2	Incidence of recurrent eclamptic fits occurring after hospital admission	Sentinel event
3	Death due to heart disease in pregnancy	No deaths
4	Occurrence of urinary tract injury following hysterectomy	>1 % of total hysterectomies

Appendix 13 : SURGICAL OPERATIONAL POLICY ON PATIENT MONITORING

1) High dependency ward (HDW)

1. All patients would be monitored on quarter hourly basis or continuously if indicated
2. Monitoring includes blood pressure, pulse rate, temperature, input and output of patient, respiratory rate and oxygen saturation.
3. Other monitoring parameters are dependent on case to case basis which includes fetal and maternal well being.

2) Labour room

1. Antenatal patients would be monitored half hourly by the midwife and fetal heart monitoring would be every 15 minutes using a Pinard stethoscope.
2. In low risk patients, a cardiotocography would be done every 2 hourly or earlier if indicated while a continuous electronic fetal heart monitoring would be done in high risk patients.
3. Post natal patients would be monitored in labour room for at least an hour after delivery before transferring out to the wards. The monitoring would be every half hourly

3) Obstetrics wards

1. All high risk patients would be monitored hourly while low risk patients would be monitored 4 hourly

2. All post natal patients after caesarean section or instrumental deliveries would be monitored hourly half hourly for 4 hours and then 4 hourly in stable
3. Post spontaneous vaginal delivery patients would be monitored 4 hourly.

4) Gynaecology wards

1. All high risk patient would be monitored hourly
2. Low risk patients would be monitored 4 hourly
3. All post operative patients would be monitored quarter hourly for the first 2 hours and then half hourly till the review by doctor

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