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Code of Practice

For Private Hospitals, Nursing Homes and Maternity Homes

**Department of Health
Hong Kong SAR, China
December 2016**



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Preface

Under the *Hospitals, Nursing Homes and Maternity Homes Registration Ordinance* (Cap 165) of the Laws of Hong Kong Special Administrative Region, China, any person who intends to operate a healthcare institution in the form of a private hospital, maternity home or nursing home must obtain prior approval from the Director of Health. Examples of categories of healthcare institutions that fall within the jurisdiction of this ordinance are private hospitals, maternity homes, nursing homes for the elderly, renal dialysis centres, treatment centres for drug dependent persons and day surgery facilities.

With the advancement of medical technology and rising community aspiration for quality services, there is growing public expectation not only for healthcare institutions to provide quality services but also the Director of Health to fulfil his role as the regulator and to keep a close monitor on the registered healthcare institutions. To enable healthcare institutions to understand the regulatory requirements, the Department of Health first issued the “Code of Practice for Private Hospitals, Nursing Homes and Maternity Homes” (CoP) in August 2003, with the latest update made in December 2016.

The CoP sets out the standards for healthcare institutions to adopt in order to provide quality care to patients. The CoP includes regulatory standards on accommodation, equipment, human resources management, policies and procedures, as well as requirements on specific types of clinical and support services. The standards are applicable to all private hospitals, nursing homes and maternity homes, unless otherwise stated. Individual healthcare institution needs to observe requirements in relevant sections set out in the CoP taking into account the scope and complexity of its functions.

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Compliance with the requirements under the CoP is a condition for the registration and re-registration of healthcare institutions.

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Interpretation of Terms

The following provides the interpretation of terms under the CoP –

“Agency staff” – means a person who is not a member of staff of the establishment. He/she works for an agency or in his/her private capacity and is employed at the request of the patient to deliver nursing / personal care. Examples of agency staff include private nurses and accompanying persons / chaperons.

“Applicant” – means the person or company or corporation applying for the registration of an establishment.

“Board of Governors” – means a committee comprising directors of the company or trustees of the corporation with at least one lay member.

“Clinical Staff” – means any person who delivers services related to the patient treatment and care in the establishment.

“Dentist” – means a dentist registered under the Dentists Registration Ordinance (Cap 156).

“Establishment” – means a hospital, nursing home or maternity home. It includes all the health service units run under the same name of the establishment. Satellite clinic is an example of health services unit considered as part of an establishment.

“Licensee” - means the applicant who has been registered in respect of an establishment. The licensee would be held responsible for any legal matters pertaining to the running of the establishment. Where the licensee is a company, the directors of the company assume the responsibilities of the licensee as stipulated in this CoP.

“Medical Practitioner” – means a medical practitioner registered under the Medical Registration Ordinance (Cap 161).

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“Medical Staff” – means medical practitioners who provide medical service for patients in the establishment and affiliated with the establishment as employees, partners or holders of admission privileges.

“Medical Laboratory Technologist” – means a medical laboratory technologist registered under the Supplementary Medical Professions Ordinance (Cap 359).

“Nursing Staff” – means registered nurses and enrolled nurses registered and enrolled, respectively, under the Nurses Registration Ordinance (Cap 164) and who provide nursing care to patients in the establishment.

“Ordinance” – means the Hospitals, Nursing Homes and Maternity Homes Registration Ordinance (Cap 165).

“Occupational Therapist” – means an occupational therapist registered under the Supplementary Medical Professions Ordinance (Cap 359).

“Patient” – means any person who obtains service from the establishment.

“Person-in-charge” – means a person who manages and is in full charge of the day-to-day operation of the establishment.

“Physiotherapist” – means a physiotherapist registered under the Supplementary Medical Professions Ordinance (Cap 359).

“Radiographer” – means a radiographer registered under the Supplementary Medical Professions Ordinance (Cap 359).

“Registered Midwife” – means a person registered under the Midwives Registration Ordinance (Cap 162).

“Registered Nurse” – means a nurse registered under the Nurses Registration Ordinance (Cap 164).

“Satellite Clinic” – means a clinic that is operated by the registered establishment but located in a separate location from the establishment.

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“Reportable Event” – means an event stipulated in clause 12.1.2 of the CoP.

“Supporting Care Staff” – includes but not limited to healthcare assistants, personal care workers, clinic assistants, ward assistants, physiotherapy assistants and occupational therapy assistants who provide direct patient care under the supervision of nursing or other health professional staff.

“Services” – include those provided directly by employees of the establishment, or indirectly through services that have been contracted out or run through a separate business contract at location of the registered address(es).

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Chapter 1 *Registration of an Establishment*

1.1 The Applicant

- 1.1.1 In the registration of the establishment, the fitness of the applicant to carry on the management and the fitness of the establishment is being considered.
- 1.1.2 Where the applicant is a person, he/she shall be of integrity and good character. He/she shall be physically and mentally fit to operate the establishment. If he/she is personally engaged in the day-to-day operation of the establishment, he/she shall possess the qualification, skills and experience necessary to manage the establishment.
- 1.1.3 Where the applicant is a company or corporation, the directors of the company or trustees of a corporation shall be of integrity and good character and physically and mentally fit to supervise the operation of the establishment.
- 1.1.4 The applicant shall fill in an application form and provide information on the proposed establishment in a manner required by the Director of Health.

1.2 The Establishment

- 1.2.1 An establishment is considered fit if the accommodation, staffing, equipment and facilities are appropriate for the services to be provided. These include the availability of supporting services in the establishment. Examples of supporting services are laboratory services, outpatient services, pharmacy services, imaging services, catering services and maintenance services.
- 1.2.2 Under the Ordinance, “hospital” means any establishment for the care of the sick, injured or infirmed or those who require medical treatment, including a nursing home. There is no distinction of hospitals and nursing homes in terms of definition in the Ordinance. In practice, hospitals are usually taken to mean premises that provide a comprehensive range of medical services with overnight beds for the treatment of persons requiring acute or rehabilitative treatment and for persons undergoing diagnostic procedures. Nursing homes, on the other hand, are premises that provide a relatively narrow

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scope of services including nursing homes for the elderly, residential centres for the medical treatment of drug dependent persons, premises where certain types of surgery or treatment can be carried out under general anaesthesia or heavy sedation, for example, termination of pregnancy. Premises where the day care treatment procedures are being carried out but not under the continual direct personal supervision of a medical practitioner are also included as nursing homes. A renal dialysis centre is an example.

- 1.2.3 It is the responsibility of the applicant to approach the Lands Department and the Planning Department as appropriate to ascertain whether use of the premises for operation of establishment is in compliance with relevant Ordinances and Regulations of Planning Department. Clearance with the Lands Department and other relevant government departments on the land use, lease conditions, building and fire services provisions, etc., should be made before submission of application for registration of the establishment to the Director of Health. Examples of the relevant government departments and Ordinances are listed in **Appendix 1**.
- 1.2.4 The licensee should ensure that the relevant Ordinances and Laws of Hong Kong are adhered to during daily operation, and comply with the Director of Health's instructions and advice at all times.
- 1.2.5 The licensee shall submit a written application to the Director of Health for the approval of any change in services or alteration works of the establishment before commencing such change(s) by taking reference from the latest version of relevant guidance notes published by the Department of Health.
- 1.2.6 The licensee who wishes to close down the establishment shall notify the Director of Health at least 3 months before closure if the establishment is a hospital, or at least 30 days before closure if the establishment is a nursing home.

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General Requirements

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Chapter 2 Organisation and Administration of an Establishment

2.1 Overview

The organisation of an establishment is crucial to the smooth administration of services in an establishment. It is pertinent that the Board of Governors takes an active role in monitoring the performance of the establishment in addition to decision-making.

2.2 General Requirements

- 2.2.1 There is a statement of philosophy and objectives which describes the nature and purpose of the work of the establishment.
- 2.2.2 There is an organisational structure which includes all categories of staff. The structure also delineates the channels of communication, lines of authority and responsibility.

2.3 Board of Governors

- 2.3.1 The licensee shall form a Board of Governors to oversee the management of the establishment. The Board shall comprise at least one lay member.
- 2.3.2 The Board of Governors is responsible for –
 - (i) the development and application of the statement of philosophy and objectives, making sure that all major decision-makers within the establishment operate accordingly
 - (ii) the overall coordination and evaluation of activities within the establishment
 - (iii) the development of policies to facilitate operation of the establishment
 - (iv) overseeing the financial management of the hospital
 - (v) ensuring the establishment’s adherence to relevant Ordinances and Laws of Hong Kong

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- 2.3.3 Meetings shall be held at regular intervals, at least quarterly interval, by the Board to review the performance of the establishment.
- 2.3.4 Members of the Board pay regular visits to the establishment at intervals not less than six months to monitor the performance of the person-in-charge and the management of the establishment. Such visits shall be documented.

2.4 Appointment of Person-in-charge

- 2.4.1 If the licensee is personally responsible for operating the establishment, he /she shall assume the role of the person-in-charge.
- 2.4.2 If the licensee is not personally responsible for operating the establishment, a person-in-charge shall be appointed to take charge of the day-to-day operation.
- 2.4.3 The licensee shall appoint a person to deputise the person-in-charge in latter's absence from duties. The qualifications and experience of the deputising person shall be appropriate to supervise the operation of the establishment.
- 2.4.4 The person-in-charge shall –
- (i) be of integrity and good character
 - (ii) be physically and mentally fit to operate the establishment
 - (iii) possess the qualifications, skills and experience necessary to manage the establishment
- 2.4.5 On appointment of a person-in-charge, the licensee shall provide him/her a letter of appointment specifying his/her duties as the person-in-charge.
- 2.4.6 The person-in-charge shall manage the establishment with care, competence and skills taking into account of the size of the establishment and the needs of the patients.
- 2.4.7 The person-in-charge should equip himself/herself with updated knowledge in the management of healthcare institutions.

2.5 Clinical Governance

- 2.5.1 Clinical governance is defined by the Department of Health, UK as “the framework through which health organisations are accountable for continuously improving the quality of their services and

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safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”

- 2.5.2 The important areas of clinical governance for the establishment should include –
- (i) the delivery of patient-centred services
 - (ii) the arrangements for accountability of quality
 - (iii) high standards of patient care and safety
 - (iv) the continuous improvement in patient services and care
- 2.5.3 The main objectives of establishing clinical governance in the organisation are to create an environment for monitoring and improving patient services in areas such as –
- (i) patient feedback
 - (ii) risk assessment and quality assurance
 - (iii) multi-disciplinary audit
 - (iv) research and evaluation of patient services
 - (v) human resource management
 - (vi) professional development and training
- 2.5.4 The Board of Governors should design a mechanism to assess the overall effectiveness of clinical governance in the establishment.

2.6 Medical Advisory Committee

- 2.6.1 Where the establishment allows the practice of medical practitioners who are not its employees, a Medical Advisory Committee should be set up to advise on matters relating to medical treatment and medical practitioners in the establishment.
- 2.6.2 The Medical Advisory Committee comprises specialists from different specialties to assist in the vetting of application of medical practitioners for admission privileges.
- 2.6.3 The Medical Advisory Committee makes recommendations on –
- (i) eligibility criteria for practising privileges of medical practitioners
 - (ii) review, renewal, restriction or withdrawal of practising privileges
 - (iii) whether or not to permit the introduction of new clinical techniques taking into consideration the training of practitioners, the equipment required and the training/experience required of other supporting clinical staff
- 2.6.4 The Medical Advisory Committee monitors and regularly reviews

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information collated on the clinical work undertaken at the establishment. Reviews include but not limited to the following –

- (i) any deaths reportable under the Coroners Ordinance (Cap 504)
- (ii) unplanned returns to operating theatre
- (iii) adverse clinical incidents
- (iv) complaints on performance of medical practitioners
- (v) quality assurance or audit reports
- (vi) events under Clause 12.1.2(A) and (B) of the CoP. For private hospitals, the review shall be performed by taking reference from relevant guidance notes promulgated by the Department of Health

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Chapter 3 *Accommodation and Equipment*

3.1 Overview

The design and condition of the establishment should be able to meet the purpose of the establishment and the needs of patient. All equipment used in the establishment should be used as intended for its purpose, in good working order and properly maintained.

3.2 Accommodation

- 3.2.1 The physical design, size and layout of the establishment are appropriate for the safe and effective delivery of services.
- 3.2.2 Lighting, temperature, humidity, ventilation and noise level are appropriate to the facilities being used.
- 3.2.3 The premises are kept clean and hygienic.
- 3.2.4 The premises are kept in a good state of repair.
- 3.2.5 There are adequate hand washing and sanitary facilities for patients.
- 3.2.6 There are facilities to provide for privacy of patients, where necessary (for example, screens).
- 3.2.7 Aids to facilitate the movement of the disabled (for examples, lifts and ramps) are available where appropriate.
- 3.2.8 Mechanism exists that all patient care buildings and physical facilities are periodically inspected. This periodic inspection is documented and helps the management develop a plan to reduce evident risks and provide a safe and secure physical environment of care.

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3.3 Equipment and Devices

- 3.3.1 Equipment is to be installed and serviced according to the manufacturer's recommendation. Equipment should not be modified unless the advice of the manufacturer or professional advice has been sought and no risk has been identified. Such advice should be documented. All equipment should conform to current health and safety regulations. There is a planned preventive maintenance and replacement programme.
- 3.3.2 All equipment are stored properly and rotated in use where appropriate to ensure that at the time of use they are in optimum condition.
- 3.3.3 Written procedures are drawn up for use and for maintenance of different types of equipment.
- 3.3.4 Medical equipment intended for single use should not be reused.
- 3.3.5 There are procedures for cleaning, disinfection, packaging, sterilisation, transportation and storage of reusable medical equipment. Medical devices are handled safely and decontaminated prior to re-use. Re-usable medical devices are decontaminated in accordance with best practice requirements or manufacturer's recommendations.
- 3.3.6 A register is kept in respect of all medical equipment used for the purposes of treatment. Such register includes:
- (i) the date of installation of the equipment
 - (ii) the model of the equipment and the name of the manufacturer
 - (iii) the name and contact telephone of the servicing agent
 - (iv) details of the maintenance of the equipment and date of servicing
- 3.3.7 Staff using medical equipment should have completed training in the safe and proper use of the equipment.

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Chapter 4 *Human Resources Management*

4.1 Overview

Healthcare service is a labour intensive business. The skills, competence and attitude of the care providers are key factors in determining the quality of care that patients will receive. It is the responsibility of the licensee to ensure that the staff or personnel who provide treatment and care in their establishment, are appropriately skilled, qualified and competent to do so.

4.2 General Requirements

- 4.2.1 There is at all times an appropriate number of suitably qualified and experienced persons in the establishment, taking into account the number and needs of patients and types of services provided.
- 4.2.2 Each person in the employment of the establishment –
- (i) is suitably qualified
 - (ii) receives appropriate training and supervision
 - (iii) has effective induction
 - (iv) is regularly appraised on his/her performance
 - (v) is conversant with policies and procedures relevant to his/her duties
 - (vi) is encouraged to undertake continuous professional development in his/her field of work.
- 4.2.3 Written and dated job description for different ranks and grades of staff is available. A clearly defined organisation chart is available so that the staff are aware of their responsibilities to facilitate team work.
- 4.2.4 The registration status of the employee is checked on a regular basis.
- 4.2.5 A record is kept for each employee with the following detail –
- (i) name and identifier of the person
 - (ii) details of his/her position and duties
 - (iii) date of employment and change in working locations
 - (iv) details of professional qualifications and valid registration with relevant professional regulatory body
 - (v) record and/or valid certificate of all training and educational

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activities

- 4.2.6 All clinical staff are required to abide by relevant codes of professional practice.
- 4.2.7 A record of duty roster is kept for all services/wards.
- 4.2.8 All staff should wear staff badges with name and post to identify themselves to clients.

4.3 Medical Staff

- 4.3.1 Where the establishment caters for acute in-patient service, there is a resident medical practitioner available on immediate call within the establishment at all times to provide urgent patient care.
- 4.3.2 There should be a roster for medical practitioners to deal with emergencies. The roster should be devised in such a manner so as to avoid the same doctor being put on-call for a prolonged period without replacement or backup.
- 4.3.3 Resident medical practitioners should undertake certified training in advanced life support, which is updated regularly. Where children are admitted as in-patients, resident medical practitioners should also hold a valid certificate in Paediatric Advanced Life Support (PALS) or equivalent.
- 4.3.4 Where the patient requests a specialist to provide the service, the medical practitioner providing the service should be one whose name has been included in the specialist medical register of the Hong Kong Medical Council or equivalent.

4.4 Medical Practitioners and Health Professionals with Practising/ Admission Privileges

- 4.4.1 For practitioners/professionals (personnel) with admission or practising privilege, there is a mechanism to –
 - (i) vet their fitness in terms of qualifications, experience and training
 - (ii) check the indemnification/medico-legal protection
 - (iii) monitor their performance
 - (iv) update them of current requirements of the establishment
 - (v) cancel their admission privileges if they are not fit or where the services provided are not of quality or that their

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performance violates the relevant professional code of practice or that they have not complied with requirements of the establishment

- 4.4.2 For practitioners who wish to carry out new procedures, techniques or treatment modalities, they should provide evidence of relevant training. Prior approval should be obtained from the Medical Advisory Committee.
- 4.4.3 There is a mechanism for staff to report to the person-in-charge on irregular or unsatisfactory performance of these personnel.
- 4.4.4 A personal record is kept for each of these personnel which includes the following information –
 - (i) name and identifier of the person
 - (ii) details of professional qualifications and valid registration with relevant professional regulatory body
 - (iii) the specialty permitted to be practised
- 4.4.5 There is a written agreement with these personnel setting out the details of practising privileges and his/her consent to comply with the rules and regulations of the establishment. Such agreement is renewed on a regular basis.
- 4.4.6 These personnel are required to place a copy of all clinical notes relating to the period of stay in the establishment in the patient's medical record.
- 4.4.7 These personnel are required to respond to complaints raised against their performance.
- 4.4.8 The communication arrangements of practitioners (for example, mobile phone and pager numbers) are accurately documented and updated where appropriate.

4.5 Nursing Staff

- 4.5.1 The overall nurse-in-charge (nursing head) should be a registered nurse with experience in nursing administration.
- 4.5.2 In the absence of a nursing head, another registered nurse is authorised to act for him/her.

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- 4.5.3 Registered nurses who have received relevant training are required to be the duty nurse-in-charge in the following services / specialties – intensive care units, cardiac catheterisation centres, operation theatres, emergency services, obstetric and nursery service, day surgery / endoscopy services, haemodialysis units, oncology service and geriatric service. In the absence of the duty nurse-in-charge, another registered nurse who have received relevant training is authorised to act for him/her.
- 4.5.4 There is a routine relieving mechanism and an emergency staff mobilisation plan in place to ensure adequate nursing manpower at all times and whenever necessary.

4.6 Supporting Care Staff

- 4.6.1 All supporting care staff have undergone training and being assessed to be competent.
- 4.6.2 They work under the supervision of nursing or other health professional staff.
- 4.6.3 Policies and procedures that are relevant to their areas of work are presented in a form that they can understand.

4.7 Agency Staff

- 4.7.1 All agency staff should have an appropriate induction and are made aware of current policies and procedures of the establishment.
- 4.7.2 The establishment should vet the qualification of agency staff in the case of professional staff. The performance of the agency staff should be monitored.
- 4.7.3 The staff of the establishment should not influence the patients to employ agency staff.
- 4.7.4 Where a patient wishes to employ agency staff, there is written information made available to the patient on the qualifications and charges of different types of agency staff.
- 4.7.5 The patients are informed of the responsibilities of agency staff, the relationship of the agency staff with the establishment and the legal liability in case of medical incidents arising from the performance of the agency staff concerned.

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4.8 Staff Development and Education

- 4.8.1 There is a job orientation programme to introduce new staff to the relevant aspects of the service. The programme aims to prepare them for their role and responsibilities. This includes –
- (i) information about the philosophy and objectives of the establishment and of each department/unit
 - (ii) information about the relationship between each department/unit and the total organisation of the establishment
 - (iii) duties and functions, lines of authority, areas of responsibility and methods of obtaining appropriate resources
 - (iv) methods that will be used to evaluate the service as well as the performance of staff
- 4.8.2 Special orientation programmes are conducted for services which demand special awareness of technology or safety, such as operating theatre services, intensive care units and radiology services.
- 4.8.3 Opportunities are provided for staff to receive on-the-job training, in-service education and continuing education where appropriate.
- 4.8.4 Current operation manuals and clinical guidelines are easily accessible and available to staff for their reference.

4.9 Other requirements

- 4.9.1 According to the Employees' Compensation Ordinance (Cap 282), the operator of an establishment should provide employees' compensation insurance against his/her liability to all employees. Besides, it is desirable for the operator to provide insurance coverage for the establishment, for example, public liabilities.

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Chapter 5 *Quality Management of Services*

5.1 Overview

It is of paramount importance that services provided in the establishment are of quality and appropriate to the needs of patients. Patients should receive timely assessment of their health problems and appropriate treatment and care. Quality assurance is an objective and systematic monitoring and evaluation of the health services provided. It provides the establishment a basis for improvement of its service.

5.2 Quality Management

- 5.2.1 The management adopts an attitude and an orientation that permeates the establishment to strive for excellence and continuous improvement to meet the expectations of the internal and external customers. Staff accept responsibility for the quality of their work, and achieve genuine commitment and active involvement from the management.
- 5.2.2 The management must plan to improve its performance in a systematic, coordinated and continuous manner. The approach to improving performance should be described by the management in order to tie in with the vision, mission, finance, day-to-day operations and culture of the establishment.
- 5.2.3 Managing for quality is performed by the use of the concepts of quality planning, quality control and quality improvement.
- 5.2.4 Each clinical service has continuous quality improvement activities that are part of the overall hospital-wide plan.

5.3 Quality Committee

- 5.3.1 A Quality Committee comprising members from multidisciplinary services is set up to prescribe standards of care and service. The Chairman or members of the committee have received training in conducting quality assurance activities.
- 5.3.2 The Quality Committee implements a system for reviewing the

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quality of services at appropriate intervals. Such review may take the form of internal audit or external accreditation programmes.

- 5.3.3 Quality improvement plans for the establishment are developed after taking in views and suggestions from front-line staff. The plans are prioritised by the Quality Committee for implementation.
- 5.3.4 The Quality Committee examines reports of reviews conducted on the quality of the services. Reports on reviews or quality assurance activities are made available for the inspection of the Director of Health.
- 5.3.5 The quality improvement and patient safety programme is organisation-wide. Successful improvements are documented and circulated to all staff.
- 5.3.6 The Quality Committee follows up on findings of reviews or programmes to assure that effective corrective actions have been taken, including policy revisions, procedural changes, educational activities and follow-up on recommendations.

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Chapter 6 Policies and Procedures

6.1 Overview

Policies provide the framework within which activities are to be carried out within the establishment. There are general policies which apply on an establishment-wide basis covering items such as patient rights, ethics, health and safety. There are also specific procedures for each service. These procedures provide clear directives as to the scope of service, the responsibilities and activities of staff.

6.2 General Requirements

6.2.1 Policies and procedures are –

- (i) clearly set out in an understandable language
- (ii) documented in a policy manual readily accessible to staff
- (iii) drawn up on the basis of adequate information and in consultation with relevant professionals
- (iv) feasible of being implemented
- (v) in compliance with guidelines/codes/regulations/standards issued by professional bodies and Government
- (vi) not in conflict with relevant legislations

6.2.2 Policies and procedures are developed in the following areas –

- (i) admission policy for patients
- (ii) staff management
- (iii) patient care
- (iv) patient safety
- (v) risk assessment
- (vi) handling of information
- (vii) patients' rights
- (viii) complaints handling
- (ix) charges
- (x) research activities
- (xi) quality assurance activities
- (xii) specific requirements and handling procedures for each service

6.2.3 There is a central register of policies and procedures that includes the title, issue date and review date.

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- 6.2.4 There is a mechanism to ensure staff are conversant with relevant procedures. Measures may include circulation of procedure manuals to staff concerned at regular intervals.
- 6.2.5 Evaluation is carried out regularly on the practice against the procedures to ensure effective implementation.
- 6.2.6 Policies and procedures are reviewed at intervals not more than three years and revised as necessary to reflect the current scientific knowledge of services.

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Chapter 7 *Rights of Patients*

7.1 Overview

Patients have the right to be treated with dignity. All services are to be delivered without discrimination with respect to the age, sex, religion, ethnicity and disability of the patient. They have a right to be informed of the treatment planned for them. There should also be a system to address their complaints.

7.2 General Requirements

- 7.2.1 There are written policies and procedures to protect the following rights of the patients –
- (i) the right to obtain information on one's own diagnosis, treatment, progress and investigation results
 - (ii) the right to obtain information necessary to give informed consent to any investigation, procedure, surgery or other treatment modalities; such information includes clear and comprehensive information about the procedure, its effectiveness and any risks associated with it and any alternatives to the treatment recommended
 - (iii) the right to refuse treatment after being explained of the consequence
 - (iv) the right to confidentiality in all communications and records related to one's own care
 - (v) the right to refuse experimentation or participation in teaching programmes
 - (vi) the right to know the fees and charges prior to consultation and any procedure
 - (vii) at admission, staff is instructed to respond to / answer patient or his / her family member's enquiry about the expected charges for the use of hospital services or facilities; in parallel, mechanism exists that patient during hospitalisation is kept informed of the updated charges of care at suitable intervals
 - (viii) the right to examine and receive explanation on one's bill
 - (ix) the right to obtain a medical report or a copy of the medical record from the establishment and the attending medical practitioner after paying respective processing charges
 - (x) the right to be informed of any public health measures taken in the establishment and to take appropriate measures to

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protect their health

- 7.2.2 There are appropriate facilities to ensure privacy and to meet the special needs of patients.
- 7.2.3 The patients have a right to know the name and rank of the staff providing services. Staff should wear badges with name and post title to identify themselves. The badge should be visible to the clients. The patients have a right to know the qualifications of the medical practitioner providing the service.
- 7.2.4 There are appropriate measures to protect patients' personal belongings from theft or loss and also measures to protect patients from assault by visitors, other patients, and staff. This responsibility is particularly relevant to infants and children, the elderly, and others unable to protect themselves or signal for help.

7.3 Charges

- 7.3.1 A schedule of charges is prepared with respect to room charges, investigative and treatment procedures, medical supplies, medicines, medical report, photocopy of medical records and any charges that will be levied. This is available for reference of patients at the admission office, cashier and where appropriate.
- 7.3.2 The schedule of charges is updated when there is a change in the charges.
- 7.3.3 The patient is informed of the charges of service where practicable.
- 7.3.4 Feedback on charges of individual patient is provided to their medical practitioners with admission privileges for their reference.

7.4 Handling of Complaints

- 7.4.1 A mechanism is in place for handling complaints made by a patient or a person representing the patient.
- 7.4.2 The mechanism consists of procedures for receiving, investigating and responding to complaints. A time frame is set for staff to provide initial response to complaints, for example, 10 working days.
- 7.4.3 A notice on the channels for receiving complaints is posted up for

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patients' information at the admission office, reception counter of individual service, cashier and reception hall.

- 7.4.4 A staff is assigned as the patient relation officer to handle complaints.
- 7.4.5 A record of the details of the complaints received, investigation findings and actions taken is kept.
- 7.4.6 A complaint digest is provided by private hospitals to the Director of Health on a monthly basis.
- 7.4.7 Staff and related personnel of the hospital regularly receive training on customer service improvement, such as mediation skills.

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Chapter 8 Patient Care

8.1 Overview

Patients with certain clinical conditions warrant special attention. It is essential for the licensee to identify the type of conditions that warrants special attention; and to plan and monitor the service accordingly. For individual patients, the medical practitioner in charge of the patient assumes the most important role in delivering appropriate care. The following standards relate to the care of patient in general, care of critically ill patient, care of patients who require restraint and care of children.

8.2 Care of Patients in General

- 8.2.1 There is a medical practitioner who is in charge of the patient and accountable for the care of the patient during his/her stay in the establishment. The medical practitioner is responsible for coordinating medical services to be provided to the patient.
- 8.2.2 For patients who are admitted to an establishment by a medical practitioner with admission privilege, that practitioner assumes the role of the practitioner in-charge of the patient. When there is a change in the practitioner in-charge, the patient should be informed accordingly.
- 8.2.3 When the patient is admitted to the establishment, there is timely assessment by the practitioner in-charge of the patient.
- 8.2.4 During the stay of the patient in the establishment, the medical practitioner in-charge should regularly follow up the patient taking into consideration of the clinical condition.
- 8.2.5 In nursing homes not providing 24-hour resident medical practitioner coverage, the patient and his/her next-of-kin must be informed of the arrangement of medical service of the home before admission.
- 8.2.6 Patients should be properly assessed by a medical practitioner prior to undergoing any intervention.

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- 8.2.7 Assessments and / or procedures performed are documented in the patient's records and readily available to those responsible for the patient's care.
- 8.2.8 Patients and families are informed about the outcomes of care and treatment including unanticipated outcomes.

8.3 Care of the Critically Ill Patient

- 8.3.1 Hospitals shall have at least one team of staff on duty at all times in the establishment and readily available to provide resuscitation. The team should comprise at least one medical practitioner. All team members shall have valid certificates in Basic Life Support (BLS) and at least one member shall have a valid certificate in Advanced Cardiac Life Support (ACLS) or equivalent. Where children are admitted as in-patients, there is at least a member of staff with valid certificate in Paediatric Advanced Life Support (PALS) or equivalent on duty at all times in the establishment and readily available to provide resuscitation.
- 8.3.2 Nursing homes shall have at least one medical or nursing staff who has received training in resuscitation on duty at all times in the establishment and readily available to provide resuscitation.
- 8.3.3 The staff who need to provide resuscitation should have updated training on a regular basis, with resuscitation drills carried out regularly. The establishment should conduct audit on the skills to assess the competence of staff concerned.
- 8.3.4 Resuscitation equipment includes at least the following items –
- (i) ambu bag
 - (ii) oxygen supply
 - (iii) suction
 - (iv) defibrillator
 - (v) infusion drip sets and fluids
 - (vi) drugs as advised by the Medical Advisory Committee
- 8.3.5 Resuscitation equipment is made easily accessible and staff is aware of its location.
- 8.3.6 Resuscitation equipment and medication is made ready in accordance to the age of the patients. For example, where the establishment receives neonates or children, paediatric dosage for medication is made ready where practicable.

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- 8.3.7 Resuscitation equipment is checked and restocked to ensure all equipment remains in good working order at all times. Checks are documented with the staff's signature.
- 8.3.8 Written policies and procedures are prepared in relation to resuscitation of patients.
- 8.3.9 Written policies and procedures are in place to guide the handling, use, and administration of blood and blood products for critical patients.

8.4 Care of Patients/Nursing Home Residents who Require Physical Restraint

- 8.4.1 Use of restraints is discouraged and should only be used as the last resort to prevent patient from injuring himself/herself or others or to prevent the patient from falling.
- 8.4.2 Restraints are applied by a nursing staff in consultation with a medical practitioner who has assessed the suitability of using restraints, the type and the maximum duration. The need is documented in the patient/resident's clinical record.
- 8.4.3 Where restrainers are to be used, the informed consent of the patient or his/her next-of-kin or other authorised representative is obtained.
- 8.4.4 Written policies and procedures are developed on the use of restrainers to ensure the proper use of restraint.
- 8.4.5 The restraint allows a patient to breathe freely. Minimal movement of body and limbs is permitted.
- 8.4.6 The condition of the patient/nursing home resident (including the circulation and skin integrity) is checked on a regular basis to ensure that the patient is safe from the risk of strangulation. There is a record to document such checking.

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8.5 Care of Children

- 8.5.1 Treatment is provided by persons who have appropriate qualifications, skills and experience in treating children.
- 8.5.2 Arrangements are made to meet the medical, physical, psychological and social needs arising from the age of the child.
- 8.5.3 All staff who care for or treat children are trained to recognise the signs and symptoms of child abuse and initiate appropriate action by taking reference from the latest guidelines related to child abuse issued by the Social Welfare Department, for example, “Procedural Guide for Handling Child Abuse Cases”.
- 8.5.4 Toys provided for use by children are safe and cleaned after use.
- 8.5.5 Where the establishment caters for neonates, there are policies and procedures to support breast feeding, such as rooming-in facilities and a breast feeding support team.

8.6 Care of Patients who Require Palliative Care

- 8.6.1 The multi-professional team is commensurate with the service being provided.
- 8.6.2 All team members are trained in the assessment of palliative care needs across the dimensions of physical, psychological, social, religious and cultural needs.
- 8.6.3 All team members have received training and updating in communication skills and the breaking of bad news.
- 8.6.4 Resuscitation policies are in place and information is available for patients and their carers. Healthcare professionals with thorough understanding of the resuscitation policy and its application are on duty at all times in the establishment and are available to make resuscitation decisions.

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Chapter 9 Risk Management

9.1 Overview

Risk is present in the physical environment, equipment, chemicals, drugs or hazardous substances being used. Patients are also at risk when unsafe practices, treatment and investigation procedures are carried out. Managing risks is an integral part in the management of an establishment. The objective is to ensure that the premises, the systems of work and practices are safe. There is also greater awareness of danger and preparedness to deal with emergencies through identification, analysis, assessment, minimisation and monitoring of risk.

9.2 General Requirements

- 9.2.1 There is a comprehensive written risk management policy and supporting procedures, covering the following –
- (i) the assessment of risks throughout the establishment
 - (ii) the identification, analysing and learning from adverse health events or near misses
 - (iii) the arrangement for responding to emergencies, for example, fire evacuation, cessation of water and electricity supply
- 9.2.2 There should be a person appointed to coordinate risk assessment and promulgate information on risk identifications and solutions.
- 9.2.3 In the management of a serious incident, there should be -
- (i) a designated senior staff to co-ordinate the immediate response to the incident
 - (ii) alert procedures to deploy staff in response to an incident
 - (iii) procedures to communicate the nature of the incident to senior staff, family of the patient, regulatory authorities and media as appropriate (risk communications)
 - (iv) investigation and audit after the incident
 - (v) implementation of recommendations to prevent future occurrence
- 9.2.4 The licensee should notify the Director of Health on the occurrence

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of reportable events as stipulated in Clause 12.1.2 of the CoP in the establishment.

- 9.2.5 There is an on-going process for identifying and reducing unanticipated adverse incidents and safety risks to patients and staff.

9.3 Fire Safety

- 9.3.1 Advice is sought from the Fire Services Department (FSD) or agencies approved by FSD on the measures on fire safety.
- 9.3.2 Adequate precautions against the risk of fire are taken.
- 9.3.3 Procedures are drawn up on fire precaution and contingency plans in case of fire. These procedures are reviewed at intervals not exceeding 24 months.
- 9.3.4 The use of fire-resistant materials for mattresses and upholstered furniture are in line with standards prescribed by the FSD.
- 9.3.5 Procedures to be followed in the event of fire are displayed in conspicuous places in the premises.
- 9.3.6 Fire evacuation exercise is conducted at regular intervals. Records of the drills should be made available for inspection.
- 9.3.7 The fire and smoke safety plans including systems related to early detection and suppression are subject to regular testing and results are documented.

9.4 Health and Safety of Staff

- 9.4.1 The establishment should comply with the Occupational Safety and Health Ordinance (Cap 509) to safeguard the health and safety of staff.
- 9.4.2 A record should be kept on accidents to staff.

9.5 Safety of Patients with Mental Problems or Violent Behaviour

- 9.5.1 If it is the policy of the establishment to admit patient with mental problems or violent behaviour, there are policies and procedures to –
- (i) assess the patient's inclination to violence and self-harm

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- (ii) assess the quality, safety, appropriateness and security of the service facilities to prevent the patient harming himself/herself or other person
- (iii) provide training to enable staff to manage such patients
- (iv) communicate the patient's condition to staff who are taking care of the patient
- (v) manage a disturbed patient
- (vi) prescribe the use of restrains, rapid sedation and emergency medication where applicable
- (vii) report of incidents or self-harm

9.5.2 The attending medical practitioner should carry out an examination on the mental condition of the patient suspected to have suicidal tendency and take appropriate action. Staff need to monitor the condition of the patient and increase vigilance where appropriate.

9.6 Infection Control

9.6.1 There is an infection control team to deal with infection acquired or brought into the establishment. The team also monitors the incidence and trends of infections among patients and staff as well as infection control activities. For hospitals, there is a high level infection control committee to monitor the work of the infection control team, develop infection control policies, to endorse infection control guidelines, to meet the budget and staff requirement for carrying out the infection control programmes.

9.6.2 Members of the team have received training in infection control.

9.6.3 The team also provides advice in relation to the following issues –

- (i) early stage planning relating to the building services and the purchase of medical equipment
- (ii) contracting-out process for services which have implications for infection control, for example, laundry, housekeeping, waste disposal, catering, sterile supplies and maintenance of ventilation system

9.6.4 Written policies, procedures and guidance for the prevention and control of infection are developed, including the following, wherever is relevant to the establishment –

- (i) standard and transmission based infection control precautions
- (ii) hand hygiene procedures and facilities
- (iii) safe handling and disposal of clinical waste, cytotoxic waste

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and chemical waste

- (iv) management of nasogastric tubes and indwelling catheters
- (v) decontamination and reprocessing of re-usable medical devices
- (vi) collection, packaging, handling and delivery of laboratory specimens
- (vii) notification of suspected outbreak of infectious disease to the Centre for Health Protection of Department of Health and management of the outbreaks
- (viii) isolation of patients suffering or suspected to be suffering from infectious disease
- (ix) prevention of occupational exposure to blood borne viruses and other infections through barrier precaution or vaccination
- (x) antibiotic policy/usage
- (xi) injection safety and management of needle-prick injury
- (xii) management of spills or accidents with infectious substances
- (xiii) equipment cleaning, disinfection and sterilisation
- (xiv) management of laundry and linen
- (xv) operation of catering service
- (xvi) identify environmental infection risk during demolition, construction and renovation works
- (xvii) indications and use of personal protective equipment under different infection risks
- (xviii) catheter related bacteraemia
- (xix) catheter related urinary tract infection
- (xx) ventilator associated pneumonia
- (xxi) surgical site infection

9.6.5 The work of infection control team is supported by timely medical support and microbiological service in case of a hospital.

9.6.6 The infection control team undertakes on-going activities and surveillance to monitor nosocomial infections, outbreaks of infectious diseases and to detect multi-drug resistant organisms.

9.6.7 Appropriate negative pressure rooms or independently ventilated rooms are available for isolation of patients with infections spread by airborne route.

9.6.8 The infection control team, headed by a designated and trained infection control practitioner, is tasked to monitor, organise and implement infection control practice.

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- 9.6.9 The infection control team involves in training of staff on all aspects of infection prevention.
- 9.6.10 There is a mechanism to integrate infection control practice with the establishment's overall programme for quality improvement and patient safety.
- 9.6.11 The team should keep abreast of the situation of infectious diseases in the community and implement appropriate infection control measures.

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Chapter 10 *Medical Records*

10.1 Overview

A comprehensive medical record is maintained for each patient. The record is a contemporaneous record of all treatment provided by all health professionals. It enables the health team to provide continuing care to the patient. Please refer to the section of “Medical Records” in the “Code of Professional Conduct for the Guidance of Registered Medical Practitioners” issued by the Medical Council of Hong Kong.

10.2 General Requirements

- 10.2.1 All medical records are accurate, sufficiently detailed, legible, current, complete and organised to enable –
- (i) the medical practitioner responsible for the patient to provide continuing care to the patient, to review the diagnostic and therapeutic procedures performed and the patient’s response to treatment
 - (ii) another medical practitioner to assume the care of the patient at any time or at times of emergency
 - (iii) the retrieval of information required for review and quality assurance activities
- 10.2.2 The patient’s name in full, patient / hospital number or alternative identifier are displayed conspicuously on the record sheet for easy identification. The record of the patient comprises the following but not limited to –
- (i) notes of all medical practitioners, allied health professionals and their identification, who have attended the patient in the establishment, for example, admission notes, consultation notes and progress notes
 - (ii) prescription order form
 - (iii) observation charts and fluid balance charts
 - (iv) drug charts and history of allergy
 - (v) reports of laboratory, radiological and diagnostic services
 - (vi) films or clinical photos
 - (vii) consent forms
 - (viii) anaesthetic records, including pre-operation assessment, pre- and post- anaesthesia record, date and place of operation
 - (ix) operation records including the histopathology report if tissue

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or body fluid was removed for examination, detail of the site of the operative procedure, surgeon's signature

- (x) referral letters
- (xi) nursing care plans
- (xii) any adverse incident, including injuries to the patient
- (xiii) discharge summary with diagnosis, key investigation results, treatment given and medications on discharge

10.2.3 All entries in the patients' records are dated. The time is entered where appropriate. It bears the signature of the service provider. The signature should be recognisable or traceable. A specimen of signature should be kept. Alternatively, the signature is accompanied by the name of the signatory. Incorrect entry or error made is crossed out and corrected where appropriate with the date and signature of the correcting officer.

10.2.4 Where the medical record is in an electronic format, there is a mechanism to provide an audit trail on any amendments made on the record.

10.2.5 The management regularly audits the content and completeness of patient medical records.

10.3 Storage and Destruction of Records

10.3.1 A policy is set to retain medical records for a certain period of time. The period depends on the nature of the record and the likelihood of legal proceedings. The administration can consult its legal advisor on how long should specific types of records be stored.

10.3.2 The record of the patient is kept in a confidential manner. All records should be kept in a secure place to prevent access by unauthorised persons, damage or loss. Security measures and policies are in place for the safe handling and transmission of electronic information containing patients' data including, among others, electronic mails or those stored on removable media such as floppy disks, tapes, USB hard drives and flash memory devices, etc.

10.3.3 Destruction of records including electronic records or images containing patients' data is undertaken in a secure manner.

10.4 Special Registers

10.4.1 A register of patients is maintained. The registry can be in

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electronic or written format. The information to be included is as follows –

- (i) the name, sex, date of birth, personal identifier, address and telephone number of each patient
- (ii) the number given to identify the medical record of that particular admission, for example, hospital number and centre number
- (iii) the date of admission
- (iv) the date of discharge, transfer or death

10.4.2 A register is maintained on the details of medical devices implanted that serves critical purposes. Pacemakers are examples of medical devices used for critical purpose. The register should contain the name or identifier of the patient, the brand, model, batch number and serial number of the device and the date of implant. This information is to allow subsequent tracing.

10.4.3 A register is maintained on the particulars of the patients receiving pharmaceutical products that are derived from human sources. Examples are plasma and its derivatives.

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Chapter 11 Research

11.1 Overview

The “Code of Professional Conduct for the Guidance of Registered Medical Practitioners” issued by the Medical Council of Hong Kong provides guidance on good clinical research practice. Each establishment should set out its policy on whether clinical research would be allowed on patients.

11.2 Requirements

- 11.2.1 The organisation should set up an Ethics Committee to monitor clinical research.
- 11.2.2 The purpose of an Ethics Committee is to review clinical research to safeguard the dignity, rights, safety and well-being of all actual or potential participants.
- 11.2.3 The Ethics Committee should provide independent and timely review of the ethics of proposed study.
- 11.2.4 Before any clinical research is to be carried out, a research proposal should be prepared and submitted to the Ethics Committee for approval.
- 11.2.5 The Ethics Committee should be multi-disciplinary and multi-sectoral in composition, including independent scientific expertise, professionals and specialists.
- 11.2.6 The Ethics Committee should have clear procedures in selecting and recruiting members. Conflicts of interests should be avoided when making appointments.
- 11.2.7 For study involving pharmaceutical products that are not yet registered with the Pharmacy and Poisons Board, a Certificate for Clinical Trial/Medicinal Test is required under the Pharmacy and Poisons Regulations.
- 11.2.8 The findings of the research or study conducted in the establishment are submitted to the Ethics Committee.

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Chapter 12 *Information to be Submitted to Director of Health*

12.1 Requirements

- 12.1.1 The administration is responsible to submit the following information at regular intervals to the Director of Health –
- (i) utilisation rate of facilities and services
 - (ii) births, deaths and disease classification of in-patients treated
 - (iii) staffing situation
 - (iv) audited financial report
 - (v) complaint digest (for hospitals)
 - (vi) any other information as required by the Government

- 12.1.2 The management is required to inform the Director of Health in case of the following occurrence –

For events under items (A) and (B), the reporting should be made within 24 hours with full report submitted to the Director of Health within 4 weeks.

(A) Hospital / Maternity Home:

Sentinel Events

- (i) Surgery / interventional procedure involving the wrong patient or body part
- (ii) Retained instruments or other material after surgery / interventional procedure
- (iii) ABO incompatibility blood transfusion
- (iv) Medication error resulting in major permanent loss of function or death
- (v) Intravascular gas embolism resulting in death or neurological damage
- (vi) Death of an in-patient from suicide (including home leave)
- (vii) Maternal death or serious morbidity associated with labour or delivery
- (viii) Infant discharged to wrong family or infant abduction

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- (ix) Other adverse events resulting in permanent loss of function or death (excluding complications)

Serious Untoward Events

- (i) Medication error which could have led to death or permanent harm or carries a significant public health risk
(ii) Patient misidentification which could have led to death or permanent harm

(B) Nursing Home:

Significant Incidents

- (i) Unanticipated death or major permanent loss of function (not related to the natural course of the patient's illness or underlying condition)
(ii) Serious reaction after blood or blood products transfusion
(iii) Suicide, assault, homicide
(iv) Medication error (for example, over dosage or wrong drugs) associated with adverse outcome (for example, hospitalisation) or error which involves more than two residents / inmates / patients
(v) Unanticipated accidents (for example, fall, choking) associated with loss of function or hospitalisation
(vi) Death or injury associated with the use of restrainers
(vii) Any events (for example, equipment-related, facility-related) associated with adverse outcome

(C) Others:

- (i) events of public health significance (for example, radiation health incidents)
(ii) serious incidents affecting the operation of the establishment, for example, cessation of water and electricity supply
(iii) outbreaks of any infectious disease
(iv) any other event as required by relevant legislations

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Chapter 13 Pathology

13.1 General Requirements

Hospitals providing acute care should provide an adequate range of pathology services to meet the needs of the services.

13.2 Staffing

- 13.2.1 A specialist in pathology is appointed to take charge of the service. Alternatively, a specialist in pathology should be appointed as an advisor to review regularly the facilities, equipment and staff training of the service.
- 13.2.2 A medical laboratory technologist I is assigned to take charge of the day-to-day operation of the laboratory. He should ensure that the procedures and tests performed by technical staff are within the scope of their professional training and experience.
- 13.2.3 At least one medical laboratory technologist is put on duty during the operating hours of the service.

13.3 Other Requirements

- 13.3.1 Where special pathology services are not available, appropriate arrangements can be made for the collection and transportation of pathology specimens to be performed in another institution by registered medical laboratory technologists.
- 13.3.2 There should be policies and procedures on the following areas –
- (i) safety aspect of the laboratory
 - (ii) maintenance of performance standards including quality control
 - (iii) recording of all specimens received and processed by the laboratory
 - (iv) arrangements for notification of urgent test results
 - (v) collection, labelling, transportation and storage of pathology specimen

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- (vi) protection of staff handling pathology specimens
- (vii) procurement of reagents
- (viii) checking on the expiry dates of reagents
- (ix) disposal of specimens and reagents
- (x) contingency plans for various emergencies including chemical spillage

13.3.3 Records should be kept for calibration and quality control programmes.

13.3.4 Records should be kept for drills on various emergencies.

13.3.5 There is a clinical laboratory quality assurance programme.

13.4 Blood Bank

13.4.1 The operation of the blood bank should be in line with the recommendations of the Hong Kong Red Cross Blood Transfusion Service.

13.4.2 Contingency plan exists to meet demands for a large amount of blood for transfusion.

13.4.3 There is proper documentation of use and disposal of all blood products maintained in the bank.

13.5 Organ Bank

13.5.1 Where the establishment operates eye bank and bone bank, the procedures should comply with the Human Organ Transplant Ordinance (Cap 465).

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Chapter 14 *Pharmacy and Dispensing Service*

14.1 **General Requirements**

- 14.1.1 There are written procedures for the procurement, recording, handling, safe keeping, safe administration, disposal and recall of medicines. All medications used should be registered drugs in Hong Kong.
- 14.1.2 A drug formulary is kept by the pharmacist or the medical practitioner in charge of the service.
- 14.1.3 The handling of poisons and dangerous drugs should be in accordance with relevant legislations.
- 14.1.4 There should be clear labelling of medicines. Stock items sent to wards should have expiry dates.
- 14.1.5 A registry for patients using items with human blood components should be kept to facilitate tracing where necessary.
- 14.1.6 There is a system to monitor the accuracy of dispensing and administration of medicines. Dispensing records should be kept and available for inspection. Medication errors or near miss incidents should be documented and reported to the responsible doctor or health professional through a process and time frame defined by the management.
- 14.1.7 Reportable events related to dispensing or administration of medicines should be reported to the Department of Health in accordance with relevant requirements.
- 14.1.8 There is a policy setting out whether the patient can bring in medicine for personal use. If this is allowed, the establishment should inform the patient of his/her responsibility to inform the attending doctor. If this is not permitted, this policy should be relayed to the patient before he/she decides to be admitted. Consent form should be signed.

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- 14.1.9 There is a regular and documented check of Controlled Drugs by a pharmacist or a dispenser.

14.2 Storage of Medicines

- 14.2.1 Medicines in current use are kept in safe custody. Where locked cabinets are used, there is a written procedure for the handover of keys at changes of shifts and for safekeeping of spare keys.
- 14.2.2 To comply with the Dangerous Drugs Ordinance (Cap 134) and the Pharmacy and Poisons Ordinance (Cap 138) and their Regulations, dangerous drugs are stored in a lockable cupboard.
- 14.2.3 Medicines for external and internal use are kept separately.
- 14.2.4 There is a system to check expiry dates of medicines and disinfectants whether these are kept in the store, put on standby for normal use, stored in fridge or wards for emergency use.
- 14.2.5 Where there is a cold chain requirement for maintaining the efficacy of medicines, there is a system to monitor and record the temperature of the transport and storage facilities. For example, there are written policies and procedures on storage and handling of vaccines by taking reference from the “Module on Immunisation” under the “Hong Kong Reference Framework for Preventive Care for Children in Primary Care Settings” promulgated by the Primary Care Office of the Department of Health.

14.3 Dispensing and Administration of Medicines

- 14.3.1 Medicines are dispensed under the supervision of a pharmacist or medical practitioner.
- 14.3.2 Medicines are administered by a registered or enrolled nurse.
- 14.3.3 Drugs packed in unit dose containers are administered immediately after the drug has been removed from the container.
- 14.3.4 A medication record is kept for each patient, the entries should be signed by the person who administers and showing –
- (i) the name and identifier of the patient
 - (ii) the name, dose, route of administration of medicine
 - (iii) the frequency and time for administering each dose
 - (iv) the date of prescription

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(v) any known medicine hypersensitivity or allergies

14.3.5 The medicine for resuscitation should be easily accessible to staff. The packaging should facilitate the process of resuscitation.

14.3.6 Where medicines are received against a prescription for a named patient, they should be administered to that particular patient and should not be used for other patients. When medicines are no longer required by the named patient, they should be returned to the pharmacy for proper handling and disposal.

14.3.7 Maintenance of the supplies of medicines in ward stock is performed by pharmacists, dispensers or registered nurses.

14.3.8 Medicines dispensed to patients for use outside the establishment are clearly labelled with the name of the medicine, directions and precautions for use.

14.4 Handling and Disposal of Cytotoxic Pharmaceutical Products

14.4.1 There are procedures to ensure the safe handling and disposal of cytotoxic pharmaceutical waste.

14.4.2 Staff involve in preparation of cytotoxic drugs receive relevant training regularly.

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Chapter 15 *Radiology or Imaging Service*

15.1 General Requirements

- 15.1.1 Hospitals that provide acute care should provide an adequate range of imaging services to meet the needs of the services therein.
- 15.1.2 The hospital complies with the Radiation Ordinance (Cap 303) of Hong Kong in the use of irradiating equipment.
- 15.1.3 There are written policies and procedures which include –
- (i) obtaining detailed clinical history such as history of allergy
 - (ii) provision of thorough explanation before written consent is sought from the patient
 - (iii) steps to be taken during the procedure and preparation
 - (iv) possible occurrence of allergic reaction(s) after administration of contrast medium
 - (v) accurate labelling of all films with the patient’s name, date of test performed and other identifiers
 - (vi) safety procedures
 - (vii) management of medical emergencies
 - (viii) other adverse reactions
 - (ix) application of infection control measures
- 15.1.4 All relevant staff are provided with dosimeter to regularly monitor the radiation exposure level.

15.2 Staffing

- 15.2.1 A specialist in radiology is appointed to take overall charge of the service. Alternatively, a specialist in radiology should be appointed as an advisor to review regularly the facilities, equipment and staff training of the service.
- 15.2.2 A Part I radiographer registered under the Radiographers (Registration and Disciplinary Procedure) Regulation of the Supplementary Medical Professions Ordinance (Cap 359) is assigned to take charge of the day-to-day operation of the service.

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15.2.3 A radiographer is put on duty during the operating hours of the service.

15.2.4 A registered nurse is available, where necessary, to provide support such as administration of medicine or assisting interventional procedures under the supervision of a radiologist.

15.3 Facilities and Equipment

15.3.1 The provision and use of facilities using ionising radiation should conform to the relevant legislation, i.e. the Radiation Ordinance (Cap 303). This also applies to the transporting, keeping, storage and disposal of radioactive waste.

15.3.2 There is sufficient space for changing rooms, storage for personal belongings of patients, film processing area, storage space for equipment and records, and toilet facilities located in the vicinity.

15.3.3 Radiation protective devices are available for staff, patient and accompanying person.

15.3.4 Resuscitation equipment and emergency drugs are available in the service at all times.

15.3.5 Specific devices are provided for specific imaging procedures, for example, hearing protection device is provided for patient undergoing the magnetic resonance imaging procedure.

15.3.6 There is a warning (in the form of lights or signs) outside the room that operates irradiating apparatus. Signage on special precautions should be written in both Chinese and English.

15.3.7 Precautions for accidental release of radiation should be taken if irradiating apparatus is on standby mode.

15.3.8 All equipment used to conduct radiology and diagnostic imaging studies are regularly inspected, maintained, and calibrated, and appropriate records are kept.

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15.4 Other Requirements

- 15.4.1 There are written procedures for use of different equipment and its precautions and contraindications.
- 15.4.2 There are written procedures for identifying patients with pacemakers and metallic implants for specific imaging procedures.
- 15.4.3 The disposal of the X-ray developer and X-ray fixer should follow relevant regulations and requirements as promulgated from time to time by the Environmental Protection Department.

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Chapter 16 *Operating Theatre Service*

16.1 General Requirements

- 16.1.1 There are written policies and procedures for the running of operating theatres, covering staffing arrangements, equipment, facilities and theatre practice. These procedures also include the following –
- (i) patient identification and checking of consent forms
 - (ii) verification of anatomical site of operation
 - (iii) counting of items such as swabs, needles, operative instruments and blades, and what to do if items cannot be accounted for
 - (iv) aseptic practices
 - (v) infection control measures
 - (vi) means of obtaining help in case of emergency
- 16.1.2 There are support services including pathology and radiology in the establishment.
- 16.1.3 An establishment where treatment under general anaesthesia is to be carried out should have critical care arrangements in place. Where there are no intensive care facilities in the establishment, major operations are not permitted to be performed. Arrangements should be in place for immediate transfer of patients to nearby hospitals with critical care services where necessary.

16.2 Staffing

- 16.2.1 A specialist in anaesthesia or surgery is appointed to take overall charge of the service. Alternatively, a specialist in anaesthesia or surgery should be appointed as an advisor to review regularly the facilities, equipment and staff training of the service. Where the surgery relates to a specialty such as gynaecology, ophthalmology, a specialist of the relevant specialty may be appointed as the advisor.
- 16.2.2 All surgeries are to be carried out by a suitably qualified, skilled and experienced medical practitioner. All general anaesthesia, spinal anaesthesia and epidural anaesthesia are provided only by an anaesthetist or trained medical practitioner under the supervision of an anaesthetist.

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- 16.2.3 A registered nurse who has been trained in operating theatre nursing or perioperative nursing is available at all times as the duty nurse-in-charge to supervise nursing care of the service.
- 16.2.4 Nursing staff are required to receive adequate training before assisting in new operating procedures.
- 16.2.5 Nursing staff who have received relevant training are assigned to assist the medical practitioner, provide care and support to the patient.
- 16.2.6 There is a medical or nursing staff who holds a valid certificate in Advanced Cardiac Life Support (ACLS) or equivalent on duty in the operating theatre at all times. At times when paediatric patients are undergoing surgery, there is a medical or nursing staff who holds a valid certificate in Paediatric Advanced Life Support (PALS) or equivalent on duty.
- 16.2.7 Trained nursing staff is assigned to carry out circulating duties in the operating theatre where surgery is performed where necessary.
- 16.2.8 An appropriate number of suitably qualified and experienced staff are in attendance at all times during each surgical procedure.
- 16.2.9 Following anaesthesia, postoperative patients in the recovery area are closely observed by the anaesthetist or a designated registered nurse who holds a valid certificate in ACLS or equivalent until they are discharged from the operating theatre. The progress of patients is clearly recorded in their medical records. For paediatric patients, the observation is conducted by the anaesthetist or a designated registered nurse who holds a valid certificate in PALS or equivalent.
- 16.2.10 The anaesthetist who administered the anaesthesia for the patient is responsible for the supervision of the recovery period and the authorisation of the patient's discharge from the recovery area.
- 16.2.11 The hospital establishes and monitors a prearranged roster of medical practitioners who are competent in surgery and anaesthesiology who could respond quickly to emergencies.

16.3 Facilities and Equipment

- 16.3.1 Each operating theatre is designed, equipped and maintained to an appropriate standard for the purpose it is to be used.

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- 16.3.2 Operating theatres are provided with ventilation systems to prevent the spread of airborne infectious disease and to minimise surgical site infection. The ventilation systems are regularly inspected and maintained to ensure effective functioning for patient and staff safety. Documentation of repair and maintenance of the systems is kept.
- 16.3.3 There is emergency supply of electricity by alternative power source.
- 16.3.4 Equipment for general anaesthesia includes at least the following items –
- (i) electrocardiograph monitor
 - (ii) blood pressure measuring device
 - (iii) pulse oximeter
 - (iv) life support systems
 - (v) continuous oxygen supply
 - (vi) full range of endotracheal tubes, immediate access to spare apparatus in the event of failure
 - (vii) laryngoscope and airways
 - (viii) suction equipment
 - (ix) infusion drip sets and fluids
- 16.3.5 If the patient is to be revived outside the operation room, an area should be designated as the recovery room or area to receive the patient. The area is provided with the following –
- (i) monitoring equipment, including ECG
 - (ii) resuscitation equipment including a defibrillator
 - (iii) sufficient space to accommodate a patient resting in a recumbent position
 - (iv) communication system for staff in the event of an accident or emergency
- 16.3.6 For establishments providing operations under local anaesthesia only, the operation room is equipped with resuscitation equipment including oxygen supply and ambu bag, suction equipment, basic intravenous setup and medication for resuscitation. A defibrillator is made available for resuscitation.
- 16.3.7 The operation theatres are maintained at acceptable levels of sterility by taking reference from the latest “ICB Infection Control Guidelines” promulgated by the Infection Control Branch of the Centre for Health Protection of the Department of Health.

16.4 Records

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- 16.4.1 All operation records must be completed in the patient's record immediately after the operation has been performed including pre-anaesthesia assessment, etc. Furthermore, each patient's post-anaesthesia status is also monitored and documented at appropriate intervals.
- 16.4.2 A registry of all surgical operations performed in the establishment should be kept. The registry can be in electronic or written format and contains the following information –
- (i) the name of the patient
 - (ii) the number given to identify the medical record of that particular admission, for example, hospital number and patient number
 - (iii) the date and nature of the surgical procedure
 - (iv) the name of the surgeon and surgery assistants

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Chapter 17 Intensive Care Service / Critical Care Unit / High Dependency Unit / Special Care Unit

17.1 General Requirements

- 17.1.1 Establishments catering for major operations should have arrangements for intensive care or critical care in place. This is a unit in which there are specially trained nursing and supportive personnel and diagnostic, monitoring and therapeutic equipment necessary to provide specialised medical and nursing care to critically ill patients.
- 17.1.2 Written policies and procedures are developed for routine procedures, emergency procedures, admission, discharge and transfer.

17.2 Staffing

- 17.2.1 A specialist in critical care or anaesthesia is appointed to take overall charge of the service. Alternatively, a specialist in critical care or anaesthesia should be appointed as an advisor to review regularly the facilities, equipment and staff training of the service.
- 17.2.2 A resident medical practitioner should be on duty in the establishment at all times and readily provides emergency treatment whenever required.
- 17.2.3 A registered nurse who has been trained in critical care / intensive care nursing is available at all times as the duty nurse-in-charge to supervise nursing care of the service when the service is in operation.
- 17.2.4 The nurse to patient ratio shall be at least 1:1 at all times for cases requiring intensive care. Only when the condition of a patient receiving intensive care becomes stable or for patients requiring high dependent care, the nurse to patient ratio could be stepped down to 1:2.
- 17.2.5 In addition to the nurses who are engaged in care of individual patients, there should be nursing staff on duty at the unit to provide backup support. A system should be in place to call for extra staff with critical care training to provide support whenever required.

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- 17.2.6 All staff of intensive care service / critical care unit / high dependency unit / special care unit who will provide emergency care to critically ill patients shall be familiar with resuscitation. Nurses should be equipped with intensive care nursing knowledge and skills. There is a medical or nursing staff who holds a valid certificate in Advanced Cardiac Life Support (ACLS) or equivalent on duty at all times.
- 17.2.7 Additional requirements for Paediatric Intensive Care Unit (PICU) / Neonatal Intensive Care Unit (NICU) / Special Care Baby Unit (SCBU) –
- (i) A specialist in paediatric medicine or anaesthesiology who has experience and competence in providing critical care to paediatric patients is appointed to take overall charge or as advisor of the service
 - (ii) A resident medical practitioner who is competent to provide emergency care to critically ill paediatric patients shall be on duty on the establishment at all times and readily provides emergency treatment whenever required
 - (iii) All staff of PICU / NICU / SCBU who will provide emergency care to critically ill paediatric patients shall be familiar with resuscitation procedures. There is a medical or nursing staff who holds a valid certificate in Paediatric Advanced Life Support (PALS) or equivalent on duty at all times at PICU, whilst there is a medical or nursing staff who has received training in Neonatal Resuscitation Programme (NRP) or equivalent on duty at all times at NICU/SCBU

17.3 Facilities and Equipment

- 17.3.1 The unit is equipped with the following facilities –
- (i) cardiac monitoring system
 - (ii) cardiac support facilities
 - (iii) ventilation support
 - (iv) infusion pumps
 - (v) oximetry monitoring system, etc.
- 17.3.2 There is equipment including portable ones for advanced life support.
- 17.3.3 There is emergency supply of electricity by alternative power source.
- 17.3.4 There are supporting 24-hour pathology service, with a blood bank, and radiology service.
- 17.3.5 The nurse station should be strategically placed to enable maximum observation of patients. For private wards or where direct

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observation is not feasible from the nurse station, close-circuit surveillance system should be installed to facilitate monitoring of patients.

- 17.3.6 There is a call bell system for the staff to call for additional staff in case of emergency.

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Chapter 18 Accident & Emergency Services

18.1 General Requirements

- 18.1.1 Hospitals operating accident & emergency (A&E) services shall provide, on a 24-hour basis, an adequate range of pathology service, radiology service, operating theatre service, pharmacy and dispensing services, intensive care service, cardiac service and other related supporting services appropriate to the needs of emergency patients.
- 18.1.2 All patients are informed about their rights in a manner they can understand. Emergency patients and families receive adequate information about the patients' condition, proposed treatment(s), and specialist doctors so that they can make appropriate decisions. Informed consent is obtained before surgery, anaesthesia, use of blood and blood products, and other high-risk treatments and procedures.
- 18.1.3 There are written policies and procedures regarding the handling of major incidents and disaster management. Relevant hospital staff are trained to familiarise themselves with the policies and procedures at regular intervals.

18.2 Staffing

- 18.2.1 A specialist in emergency medicine is appointed to assume overall responsibility of the A&E services. The specialist shall review regularly the facilities, equipment and staff training of the services.
- 18.2.2 There is at least one medical practitioner who is competent in emergency medicine on duty in the A&E department at all times during the operating hours to provide A&E services.
- 18.2.3 A registered nurse who has been trained in the practice of emergency nursing is available at all times as the duty nurse-in-charge to supervise nursing care of the service.
- 18.2.4 An appropriate number of suitably qualified and experienced staff are in attendance. Hospital shall have a policy in place to mobilise

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additional staff to attend to emergency situations.

- 18.2.5 The hospital maintains an up-to-date roster of specialty doctors who are readily available to render consultation service and necessary assistance.
- 18.2.6 Where appropriate, there must be a combination of medical and nursing staff who hold valid certificates in the following areas or equivalent on duty at all times –
- (i) Advanced Trauma Life Support (ATLS)
 - (ii) Advanced Cardiac Life Support (ACLS)
 - (iii) Trauma Nursing Care Course (TNCC)
 - (iv) Paediatrics Advanced Life Support (PALS)

18.3 Facilities and Equipment

- 18.3.1 There are adequate facilities and equipment for consultation, resuscitation, acute treatment, minor operation, etc. within the A&E services. Each room for carrying out of the respective care is designed, equipped and maintained to standards appropriate to meet patients' needs.
- 18.3.2 All medical equipment and supplies for life support shall be readily available, for example, resuscitation equipment including oxygen supply and ambu bag, vacuum suction, portable ventilator, basic intravenous setup and medication for resuscitation. For resuscitation, a defibrillator should be available.
- 18.3.3 There is emergency supply of electricity by alternative power source.
- 18.3.4 An emergency call system is available to call for assistance.
- 18.3.5 Mechanism exists to ensure that the call bell system, oxygen and suction equipment, emergency electricity supply, etc. are functioning.
- 18.3.6 Appropriate number of emergency trolleys for resuscitation is in place at all times.
- 18.3.7 Blood storage facilities are in close proximity to the emergency services. The blood bank of the hospital keeps an adequate stock of blood of common blood types and blood derivatives to cope with contingency.
- 18.3.8 There is a designated area, which is appropriately designed and

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ventilated, for managing suspected or probable patients with airborne infectious disease(s) to ensure a safe environment of care for patients and staff.

18.4 Other Requirements

- 18.4.1 The “Medical Records” in Chapter 10 of this Code of Practice shall apply. In addition, the following points are observed in documenting a patient’s records –
- (i) All assessments, procedures, treatments and other care performed and written in the patient’s records become a part of the hospital medical records system
 - (ii) The past medical records of the emergency patient, if available, are retrieved for use
 - (iii) Mechanism is in place to enable easy retrieval of the past medical records of the emergency patient preferably within 24 hours of admission
- 18.4.2 There is an on-going review of staffing levels and skills, facilities and equipment required for the operation of the emergency services. Drill on emergency care shall be conducted at regular intervals across various disciplines in the hospital to ensure staff preparedness and competence in dealing with emergency patients.
- 18.4.3 There are policies and procedures guiding a patient’s admission to the emergency services and appropriate referral or transfer of the patient to another unit of the hospital or another institution to meet the patient’s imminent care needs. There is also a policy guiding the discharge of patient.
- 18.4.4 The hospital puts in place a triage system so that priority for assessment and treatment is given based on the patient’s condition at the time of admission.
- 18.4.5 Assessments of emergency patients are completed in a timely manner.
- 18.4.6 The design, facilities, fixtures and fittings of the A&E department are able to cope with common diseases management and offer patients and staff a comfortable and safe environment.
- 18.4.7 Where a patient’s condition warrants care or treatment in another institution, the hospital makes appropriate transport arrangement

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through a well-managed process that ensures patient safety. Hospital has established effective communication and collaboration with Fire Services Department or other emergency ambulance services such as St John Ambulance, for transportation of patients to or from the A&E services of the hospital.

- 18.4.8 At admission as an A&E patient, apart from receiving information on the proposed care and the expected outcomes of that care, patient and family or his / her relatives also receive information on the expected charges for the care. Suitable staff are readily available to answer patient or his / her family's enquiry about the expected fees and charges.

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Chapter 19 *Oncology Service*

19.1 Requirements

- 19.1.1 A specialist in oncology is appointed to take overall charge of the service. Alternatively, a specialist in oncology should be appointed as an advisor to review regularly the facilities, equipment and staff training of the service.
- 19.1.2 A registered nurse who has been trained in the practice of oncology nursing is available at all times as the duty nurse-in-charge to supervise nursing care of the service.
- 19.1.3 Nursing staff who have received relevant training are assigned to provide care and support to the patient.
- 19.1.4 Chemotherapy services are provided under the direction of a specialist.
- 19.1.5 Equipment should be readily available to manage emergencies including anaphylaxis, extravasation, cardiac arrest and spillage of cytotoxics.
- 19.1.6 The process for preparation of cytotoxic drugs is carried out in a safe environment with appropriate ventilation.
- 19.1.7 There are written policies and procedures for –
- (i) obtaining written consent from patient before commencement of chemotherapy
 - (ii) precautions for the preparation of cytotoxic drugs
 - (iii) administration of cytotoxic drugs
 - (iv) prevention and treatment of complications arising from chemotherapy
 - (v) advice to patients on side effects or complications
 - (vi) use, handling, storage and disposal of chemotherapeutic agents and body wastes
 - (vii) dealing with spillage or accidental contamination

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Chapter 20 Cardiac Catheterisation Service

20.1 Requirements

- 20.1.1 A cardiologist is appointed to take overall charge of the service. Alternatively, a specialist in cardiology should be appointed as an advisor to review regularly the facilities, equipment and staff training of the service.
- 20.1.2 A radiographer who has received relevant training is assigned to provide support in each procedure room at time of operation.
- 20.1.3 A registered nurse who has been trained in the practice of invasive diagnostic / interventional cardiology is available at all times as the duty nurse-in-charge to supervise nursing care of the service.
- 20.1.4 Nursing staff who have received relevant training are assigned to assist the medical practitioner, provide care and support to the patient.
- 20.1.5 There is a medical or nursing staff who holds a valid certificate in Advanced Cardiac Life Support (ACLS) or equivalent on duty in the cardiac catheterisation service when the service is in operation.
- 20.1.6 The service takes place in a hospital with facilities for major operations and intensive care service.
- 20.1.7 There is emergency supply of electricity by alternative power source.
- 20.1.8 An emergency call system is available to call for assistance. There is adequate staff to carry out emergency procedures in a timely manner.
- 20.1.9 The service unit includes a scrub up area and a recovery area.
- 20.1.10 There are emergency trolley and defibrillator standby for resuscitation purpose.
- 20.1.11 There are written policies and procedures for –
 - (i) the admission and aftercare of patients including patient

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- education programmes
- (ii) aseptic practices and radiological safety

20.1.12 All relevant staff are provided with dosimeter to regularly monitor the radiation exposure level.

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Chapter 21 Renal Dialysis Service

21.1 Staffing

- 21.1.1 A specialist in nephrology is appointed to take overall charge of the renal dialysis service. Alternatively, a specialist in nephrology should be appointed as an advisor to review regularly the facilities, equipment and staff training of the service.
- 21.1.2 The staffing of the service should be appropriate with respect to the patient's condition, with reference taken from "Quality Initiative Recommendation in the Provision of Renal Services" prepared by the Hong Kong College of Physicians and the Central Renal Committee of the Hospital Authority.
- 21.1.3 A registered nurse who has been trained in the practice of renal dialysis service is available at all times as the duty nurse-in-charge to supervise nursing care of the service.
- 21.1.4 Staff are trained in renal dialysis and universal precautions necessary to prevent transmission of infection.

21.2 Facilities and Equipment

- 21.2.1 There is sufficient circulating space around each bed/chair for nursing practice to take place. There are arrangements to reduce the risk of cross-contamination.
- 21.2.2 There are hand-washing facilities for staff.
- 21.2.3 If hepatitis B or C infected patients are treated, isolation facilities are available.
- 21.2.4 There is a utility area (separated from clean area) provided for the handling of dirty linen and materials.
- 21.2.5 There is safe storage for chemical substances. Such substances are properly labelled.
- 21.2.6 There are basic resuscitation equipment and drugs including oxygen

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supply, suction equipment and defibrillator.

- 21.2.7 In case of interruption of electricity supply, there is a supply of backup electricity to allow for the return of blood from dialysis machines. Alternatively, the dialysis machines are fitted with mechanical devices to allow manual return of blood to the patient.
- 21.2.8 There is proper documentation of testing, repair and maintenance of dialysis machines and water purification system to ensure that they are kept in good functional order.
- 21.2.9 Disinfection of equipment and machines are carried out in accordance with the recommendations of the manufacturers.

21.3 Other Requirements

- 21.3.1 There are written policies and procedures on the service by taking reference from the latest relevant guidelines issued by the Infection Control Branch of the Centre for Health Protection of the Department of Health and the Central Renal Committee of the Hospital Authority, for example, the “Infection Control Guidelines on Nephrology Services in Hong Kong”.
- 21.3.2 There are written policies and procedures for –
- (i) the control of infection and cross-infection
 - (ii) handling emergencies within the service including sudden cessation of electricity supply, water supply and special arrangement during adverse weather conditions
- 21.3.3 For patients who are treated outside the hospital, there are explicit arrangements in place for rapid transfer to hospital facilities whenever required. The arrangements are clearly communicated to staff and regularly reviewed.
- 21.3.4 Each patient is attended by the specialist in nephrology on a regular basis.
- 21.3.5 No repair and maintenance works by the technician is undertaken when the haemodialysis procedure is in progress.

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Chapter 22 *Laser and Intense Pulse Light Services*

22.1 Staffing

- 22.1.1 A medical practitioner who has received training in laser and intense pulse light services is assigned to be in charge of the service.
- 22.1.2 The laser or intense pulse light equipment should be used by a person who has undertaken appropriate training. The establishment should maintain a register of persons who are authorised to use the equipment.
- 22.1.3 The person using the equipment should receive training and regularly update on –
- (i) characteristic features of the equipment
 - (ii) effect of light on eye, skin and body tissues
 - (iii) risks associated with the use of equipment
 - (iv) hazards from device malfunction
 - (v) safety management
 - (vi) actions to be taken in the event of an adverse incident

22.2 Facilities and Equipment

- 22.2.1 All lasers and intense light sources have labels identifying them, their range of wavelengths and maximum output power.
- 22.2.2 The equipment are regularly serviced and maintained. A record of servicing and repairs is kept.
- 22.2.3 The area around working lasers and intense light sources is controlled to protect other persons while treatment is in progress. The controlled area is clearly defined and not used for other purposes, or as access to other areas, when treatment is being carried out.
- 22.2.4 Warning signs are displayed on the equipment and on the outside of doors to the controlled area. Warning signal or light is available to indicate that the laser is in use.
- 22.2.5 There is personal protective equipment for the use of staff and patient.
- 22.2.6 Resuscitation equipment and drugs are easily accessible.

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22.3 Other Requirements

- 22.3.1 Written policies and procedures are developed by taking reference from relevant local or international guidelines, for example, the “Lasers, intense light source systems and LEDs - guidance for safe use in medical, surgical, dental and aesthetic practices” published by the Medicines and Healthcare Products Regulatory Agency (MHRA) of the United Kingdom and the “Code of Practice – Health Care Laser System: Hong Kong” jointly published by the Hong Kong Medical Association and the Hong Kong Surgical Laser Association.
- 22.3.2 There are written policies and procedures on –
- (i) the precautions to be taken before and during the use of the equipment and action to be taken in the event of an accident, emergency, or other adverse incident
 - (ii) controlled and safe access
 - (iii) authorised users’ responsibilities
 - (iv) safety checks
 - (v) prevention of use of equipment by unauthorised persons
- 22.3.3 Operators should ensure patient safety by –
- (i) checking with patients if they have any medical condition or treatment for which laser or intense light treatment would be a contraindication
 - (ii) covering the skin outside the area being treated
 - (iii) providing appropriate eye protection
- 22.3.4 Records are maintained with each operation on –
- (i) the name of the person treated
 - (ii) the date
 - (iii) the name of the operator
 - (iv) the treatment given
 - (v) any accidents or adverse effects
- 22.3.5 Patients are explained fully on complications associated with post-laser treatment and follow-up care actions.

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Chapter 23 Nuclear Medicine Service

23.1 Requirements

- 23.1.1 A specialist in nuclear medicine is appointed to take overall charge of the service. Alternatively, a specialist in nuclear medicine should be appointed as an advisor to review regularly the facilities, equipment and staff training of the service.
- 23.1.2 A Part I radiographer under the Radiographers (Registration and Disciplinary Procedure) Regulation of the Supplementary Medical Professions Ordinance (Cap 359) is assigned to take charge of the day-to-day operation of the service.
- 23.1.3 A radiographer is put on duty during the operating hours of the service.
- 23.1.4 A registered nurse is available, where necessary, to provide support such as administration of medicine or assisting interventional procedures under the supervision of the specialist in nuclear medicine.
- 23.1.5 The staff handle radionuclides under and in accordance with a licence issued under the Radiation Ordinance (Cap 303).
- 23.1.6 All equipment and machines are properly maintained and calibrated.
- 23.1.7 An emergency trolley and a defibrillator should be available for resuscitation purpose.
- 23.1.8 The storage and disposal of radionuclides is in line with the Radiation Ordinance (Cap 303).
- 23.1.9 There are written policies and procedures on –
- (i) the safe handling of radionuclides, preparation of patients for treatment and emergency situations
 - (ii) correct identification of the patient before each treatment

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Chapter 24 *Obstetric and Nursery Service*

24.1 General Requirements

- 24.1.1 There are written policies and procedures for –
- (i) systematic identification of each newborn baby from immediately after delivery and throughout the hospital stay
 - (ii) the management of all common conditions in the antenatal and postnatal wards and the labour room
- 24.1.2 There are arrangements for immediate transfer of a patient or her new born child to intensive care facilities or specialist care within the establishment or to nearby hospitals whenever necessary

24.2 Staffing

- 24.2.1 A specialist in obstetrics is appointed to take charge of the obstetric service. Alternatively, a specialist in obstetrics should be appointed as an advisor to review regularly the facilities, equipment and staff training of the service. A specialist in paediatrics should also be appointed as advisor for the same purpose.
- 24.2.2 A registered nurse who is also a registered midwife is available at all times as the duty nurse-in-charge to supervise nursing care of the service.
- 24.2.3 The healthcare professional who is responsible for caring for pregnant women and assisting at childbirth is a registered nurse who is also a registered midwife, a registered midwife, an appropriately qualified and experienced medical practitioner, or a specialist in obstetrics.
- 24.2.4 There are emergency arrangements for medical practitioners competent in paediatrics to be on-call for the support of very ill babies. The on-call roster should be devised in such a manner so as to avoid the same doctor being put on-call for a prolonged period without replacement or backup.

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- 24.2.5 There is a medical or nursing staff who holds a valid certificate in Advanced Life Support in Obstetrics (ALSO) or equivalent on duty in the obstetric service at all times.
- 24.2.6 The hospital establishes and monitors a prearranged roster of specialist in Obstetrics and Gynaecology, a medical practitioner with qualifications of FHKAM(O&G) or equivalent who could respond quickly to emergencies when the medical practitioner in-charge of the patient is unable to do so. For obstetrics emergencies, these medical practitioners should be available within 30 minutes when required. The on-call roster should be devised in such a manner so as to avoid the same doctor being put on-call for a prolonged period without replacement or backup.
- 24.2.7 Regular drills on the management of emergency maternity situations should be conducted.

24.3 Facilities and Equipment

- 24.3.1 Each delivery suite is equipped with –
- (i) cardiocograph
 - (ii) delivery table which can be adjusted to the Trendelenburg position
 - (iii) equipment for administration of analgesia
 - (iv) anaesthetic machine with emergency oxygen supply
 - (v) incubator
 - (vi) separate oxygen supply to the incubator
- 24.3.2 There are facilities to provide surgical deliveries where necessary.
- 24.3.3 There are labour rooms with emergency light and electricity supply by alternative power source.
- 24.3.4 Call bells, oxygen and suction facilities are regularly checked.
- 24.3.5 Bed screens should be available to ensure privacy of mothers.
- 24.3.6 Emergency trolleys for resuscitation are available at all times. There should be prompt supply of blood and blood products at all times.
- 24.3.7 A scrub gowning area is provided for staff and visitors at entrance to the nursery.
- 24.3.8 The nursery is equipped with –

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- (i) sufficient number of cots
- (ii) incubators
- (iii) phototherapy equipment
- (iv) suction equipment
- (v) oxygen supply

24.3.9 There is separate equipment or facility within the nursery for storage of infant formula and breast milk.

24.3.10 There are facilities to prepare milk for newborns in a hygienic manner.

24.4 Medical Record

24.4.1 The medical record includes the following in addition to those set out in the Chapter 10 on “Medical Record” –

- (i) the labour record
- (ii) the date and time of delivery and whether the result was a live-birth, still-birth or abortion
- (iii) the sex, weight and length of the newborn, head circumference, physical condition of the newborn at birth (for example, Apgar score) and any physical abnormalities detected
- (iv) the names of health professionals attending the patient during delivery
- (v) the condition of mother and newborn on discharge
- (vi) in case of surgical deliveries performed, the pre and post-anaesthesia record and the operation record

24.5 Other Requirements

24.5.1 Where antenatal screening tests are performed, test results are conveyed to the attending medical practitioners as soon as possible.

24.5.2 Before a decision is made to perform an intervention, for example, labour induction, the patient should be assessed on-site by a medical practitioner with appropriate qualifications and experience.

24.5.3 When a decision is made to perform an emergency caesarean section / operation, the person making the decision indicates clearly the urgency with which it needs to be carried out. The time from the decision to operate until the start of operation should be as soon as possible and not exceed 30 minutes.

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- 24.5.4 There are measures to ensure safe custody of babies.
- 24.5.5 Where the establishment caters for neonates, there are written policies and procedures to support breast feeding, such as rooming-in facilities and breast feeding support teams.
- 24.5.6 There are written policies and procedures for the management of common problems of newborn.
- 24.5.7 All deaths and births are reported as required by relevant legislations.

24.6 Sperm Bank and Reproductive Technology Activities

- 24.6.1 Where the establishment operates a sperm bank and reproductive technology activities, the procedures should comply with the Human Reproductive Technology Ordinance (Cap 561), Regulations and Code of Practice.

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Chapter 25 Radiotherapy Service

25.1 Requirements

- 25.1.1 Radiotherapy services are provided under the direction of a medical practitioner who is a specialist in radiotherapy.
- 25.1.2 A Part I registered therapeutic radiographer under the Radiographers (Registration and Disciplinary Procedure) Regulation of the Supplementary Medical Professions Ordinance (Cap 359) is on duty during the operation hours of the service.
- 25.1.3 A registered nurse is available, where necessary, to provide support such as administration of medicine or assisting interventional procedures under the supervision of the specialist in radiotherapy.
- 25.1.4 The staff use the irradiating apparatuses under and in accordance with a licence issued under the Radiation Ordinance (Cap 303).
- 25.1.5 All equipment and machines are properly maintained and calibrated with documentation in place.
- 25.1.6 An emergency trolley and a defibrillator should be available for resuscitation purpose.

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Chapter 26 Day Surgery (including Services for Termination of Pregnancy or Surgery/ Procedures for a Particular Specialty) and Endoscopy Service

26.1 General Requirements

- 26.1.1 There are written pre-operative procedures and guidelines for patients receiving day surgery / endoscopy, including –
- (i) provision of appropriate information and advice to a patient on the endoscopic procedure to be performed before obtaining his / her consent
 - (ii) fasting
 - (iii) medication
 - (iv) arrangement to inpatient care for post-operative complications where necessary
- 26.1.2 There are written post-operative policies and procedures, including instructions for the patient on –
- (i) pain relief
 - (ii) bleeding
 - (iii) care of post-operative site
 - (iv) possible complications
 - (v) advice on effects of anaesthesia
 - (vi) a contact telephone number in case of queries and where the establishment is not opened 24 hours a day
- 26.1.3 There are written policies and procedures for –
- (i) care of patient under intravenous sedation or anaesthesia
 - (ii) specimen handling
 - (iii) storage, cleaning, decontamination, disinfection and sterilisation of endoscopic equipment, and leak testing of endoscopes
 - (iv) use of single-use devices and radiation protection

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26.2 Staffing

- 26.2.1 A medical practitioner who is competent in the types of day surgery or endoscopy services to be provided is appointed to take overall charge of the service. Alternatively, a doctor who is competent in endoscopy services should be appointed as an advisor to review regularly the facilities, equipment and staff training of the service.
- 26.2.2 A registered nurse who has been trained in operating theatre nursing / perioperative nursing / endoscopy nursing is available at all times as the duty nurse-in-charge to supervise nursing care of day surgery / endoscopy service.
- 26.2.3 There is an appropriate number of trained and experienced staff.
- 26.2.4 Nursing staff who have received relevant training are assigned to provide care and support to the patient.

26.3 Facilities and Equipment

- 26.3.1 The room is spacious enough to accommodate all personnel, fittings and equipment and to allow all procedures and movements to be carried out effectively. There is a suitable recovery area with at least a nurse with relevant experience and training to monitor the patients during the post anaesthesia / sedation period.
- 26.3.2 The premises are provided with ventilation system appropriate to the procedure in which it is conducted and to prevent the spread of airborne infectious disease and to minimise surgical site infection. The ventilation systems are regularly inspected and maintained to ensure effective functioning for patient and staff safety. Documentation of repair and maintenance of the systems is kept.
- 26.3.3 There are adequate resuscitative equipment (such as oxygen, suction and monitoring facilities) and drugs to deal with any emergencies or complications arising from the procedure.
- 26.3.4 All endoscopic equipment and machines are regularly maintained with documentation in place.
- 26.3.5 There is a proper system of documentation to ensure regular monitoring of the cleanliness / sterility of endoscopes and accessories.

26.4 Other Requirements

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- 26.4.1 For establishment offering a limited scope of day surgery, support radiology and pathology service may not be required on site subject to the agreement of the Director of Health.
- 26.4.2 There are arrangements to entertain patients' enquiries outside operating hours.

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Chapter 27 *Dental Service*

27.1 Requirements

- 27.1.1 A dentist is appointed to take overall charge of the service. Alternatively, a dentist should be appointed as an advisor to review regularly the facilities, equipment and staff training of the service.
- 27.1.2 The dental nurse or dental surgery assistant works under supervision of a dentist.
- 27.1.3 The dental nurse or dental surgery assistant has received appropriate training. The training received is properly documented.
- 27.1.4 There are procedures for –
- (i) cleansing, sterilisation and storage of dental equipment and appliances
 - (ii) disposal of clinical waste
 - (iii) prevention of injuries caused by sharps
 - (iv) prevention of cross contamination or cross-infection
- 27.1.5 Zoning is carried out to avoid cross contamination between zones.

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Chapter 28 Geriatric Service

28.1 Requirements

- 28.1.1 The staff should have a basic understanding of the needs of the elderly.
- 28.1.2 The premises are maintained with good ventilation for adequate supply of fresh air; control of indoor temperature and humidity; and removal of any airborne contaminants such as carbon dioxide, dusts, obnoxious smell and pathogenic microorganisms.
- 28.1.3 Oxygen supply, suction equipment, and emergency trolleys with defibrillators are made available where necessary.
- 28.1.4 For the elderly persons living in nursing homes, there is a medical practitioner-in-charge of the care of each resident. Health inspection or medical consultation or follow up treatment to each resident is undertaken by the medical practitioner at least once every two weeks and when necessary.
- 28.1.5 A registered nurse who has been trained in the practice of gerontological nursing is available at all times as the duty nurse-in-charge to supervise nursing care of the service.
- 28.1.6 For the elderly persons living in nursing homes, there is adequate support from physiotherapist and/or occupational therapist when needed, as determined by the medical practitioner-in-charge according to individual residents' condition.
- 28.1.7 Guidelines are developed for –
- (i) feeding the elderly especially for those with swallowing difficulty
 - (ii) restraining for the elderly who are likely to fall or cause injury to self or others
 - (iii) skin care, oral and dental hygiene of each patient
 - (iv) early detection of abnormal behaviour or condition
 - (v) care of bedridden patients
 - (vi) care of demented patients
 - (vii) care of incontinent patients
 - (viii) insertion and care of indwelling catheter

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Chapter 29 Occupational Therapy Service

29.1 Staffing

- 29.1.1 An occupational therapist is assigned to take overall charge of the service.
- 29.1.2 The occupational therapists provide supervision on assistants and other supportive personnel.

29.2 Facilities and Equipment

- 29.2.1 There shall be sufficient equipment and supplies appropriate to the needs and the services offered.
- 29.2.2 Adequate space is provided for storing equipment and supplies.
- 29.2.3 All equipment shall be maintained at regular intervals.
- 29.2.4 Where patients are not directly and personally supervised at all times, there are call bells to call for assistance of staff. Call bells are frequently checked for their normal functions. All patients on treatment should be instructed on how to use them.

29.3 Other Requirements

- 29.3.1 There are written policies and procedures on the handling of equipment and instructions for patients.
- 29.3.2 Where the treatment involves the manipulation of aids / equipment by patients themselves, the patients are briefed on the proper handling of the equipment and the associated risk.
- 29.3.3 Treatment and advice given is documented in the patient's medical record.

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Chapter 30 *Physiotherapy Service*

30.1 Staffing

- 30.1.1 A physiotherapist is assigned to take overall charge of the service.
- 30.1.2 The physiotherapist should provide supervision on physiotherapy assistants and other supportive personnel.

30.2 Facilities and Equipment

- 30.2.1 There should be sufficient equipment and supplies appropriate to the needs and the services offered.
- 30.2.2 Adequate space is provided for storing equipment and supplies.
- 30.2.3 All equipment should be maintained at regular intervals.
- 30.2.4 Where patients are not directly and personally supervised at all times, there are call bells to call for assistance of staff. Call bells are frequently checked for their normal functions. All patients on treatment are instructed on how to use them.

30.3 Other Requirements

- 30.3.1 There are written policies and procedures for the handling of equipment and instructions to patients.
- 30.3.2 Where the treatment involves the manipulation of aids / equipment by patients themselves, the patients are briefed on the proper handling of the equipment and the associated risk.
- 30.3.3 Precautions or contraindications are relayed to patients before specific types of treatments are contemplated.
- 30.3.4 Treatment and advice given is documented in the patient's medical record.

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Chapter 31 *Services for Treating Drug Dependent Persons*

31.1 Requirements

- 31.1.1 The premises should be also registered with the Social Welfare Department under the Drug Dependent Persons Treatment and Rehabilitation Centres (Licensing) Ordinance (Cap 566) if the premises is –
- (i) intended for the treatment for drug dependence or for the rehabilitation of 4 or more drug dependent persons undergoing such treatment or rehabilitation on a voluntary basis
 - (ii) for providing residential accommodation for such persons undergoing treatment for drug dependence, or undergoing rehabilitation, at that place

For these institutions, they should comply with the requirements in the Code of Practice for Drug Dependent Persons Treatment and Rehabilitation Centres as promulgated by the Social Welfare Department.

- 31.1.2 The staff should have a basic understanding of the needs of drug dependent persons.
- 31.1.3 Before the admission of the resident –
- (i) explanation of treatment plan, for example, detoxification or maintenance programme, be given to the resident
 - (ii) consent be obtained from resident where the service is a voluntary service
 - (iii) physical examination to assess the fitness of the potential resident for admission
- 31.1.4 There are policies and procedures for –
- (i) recording vital signs including temperature, respiration, pulse and blood pressure
 - (ii) observing and monitoring of vital signs appropriate time intervals
 - (iii) determining the onset of acute withdrawal emergency according to methods established by the centre
 - (iv) ensuring any medications taken by individual resident to be in strict adherence to the prescriptions and advice of medical practitioners

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- (v) documenting all treatments given to every resident in the progress notes; noting down changes in patient's condition and his / her treatment response and outcome. Each entry shall be dated and signed timely by relevant staff
 - (vi) drugs brought in by residents. These drugs shall not be administered to patients unless they can be identified and approved by the responsible doctor
- 31.1.5 Oxygen supply, suction equipment and emergency equipment with defibrillator are made available where necessary.
- 31.1.6 The staff should discuss with the patient on the details of the treatment plan on admission.
- 31.1.7 Regular assessment on patients is undertaken by medical practitioners.
- 31.1.8 Guidelines are developed for dealing with medical and non-medical emergencies.

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Chapter 32 **Chinese Medicine Service**

32.1 **General Requirements**

- 32.1.1 Hospitals that provide traditional Chinese medicine service should comply with the Chinese Medicine Ordinance (Cap 549), relevant guidelines and codes promulgated from time to time by the Chinese Medicine Council of Hong Kong and the Department of Health.
- 32.1.2 There are adequate space and facilities, medical equipment or instruments, and supplies, which are appropriate to meet the needs of the Chinese medicine service.
- 32.1.3 Depending on the scope of service, a Chinese medicine dispensary may be required to apply for a retailer licence in Chinese herbal medicines to conduct retail business of Chinese herbal medicines in accordance with the Chinese Medicine Ordinance (Cap 549).
- 32.1.4 For Chinese medicine dispensary operating without a retailer licence in Chinese herbal medicines, the registered Chinese medicine practitioner in charge of the service shall take the overall responsibility of the operation of the Chinese medicine dispensary. In addition, individual Chinese medicine practitioner must also be professionally responsible for the Chinese medicines dispensed to patients under his care (including Chinese medicines dispensed directly by himself or by dispensers and other staff who are under his supervision).

32.2 **Staffing**

- 32.2.1 A registered Chinese medicine practitioner with valid practicing certificate is appointed to take overall charge of the service and to review regularly the facilities, equipment and staff training of the service.
- 32.2.2 Healthcare personnel who are designated to provide patient care and carry out clinical observations and other procedures have received appropriate training in Chinese medicine.
- 32.2.3 Dispensers trained in Chinese medicine are designated to prepare Chinese medicines in accordance with a prescription given by a

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registered / listed Chinese medicine practitioner.

32.3 Other Requirements

32.3.1 Medical records –

The Code of Professional Conduct for Registered Chinese Medicine Practitioners in Hong Kong and the Code of Conduct for Listed Chinese Medicine Practitioners, in addition to that set out in Chapter 10 of this Code, are duly observed.

32.3.2 Dispensing of Chinese medicines –

Where the service involves dispensing of Chinese herbal medicines or Chinese medicine granules for prescription, etc., policies and procedures should be developed with any relevant references issued and updated from time to time by the Chinese Medicine Council of Hong Kong.

32.3.3 Where Chinese herbal medicines are decocted for patients, the following means and facilities are in place –

- (i) appropriate area with good ventilation for decocting
- (ii) appropriate decocting devices and utensils
- (iii) appropriate storage for residues of decocted Chinese herbal medicines to allow for examination when necessary

32.3.4 Storage of medicines –

The store room is maintained in a sanitary condition, kept cool, dry and well ventilated. Appropriate measures are taken for the control of insects, rodents, mould, humidity and contamination.

32.3.5 Any Chinese herbal medicines belonging to Schedule 1 of the Chinese Medicine Ordinance (Cap 549) should be properly stored and separated from other medicines.

32.3.6 Chinese medicines are separately stored from other substances. Chinese medicines for internal use are stored separately from those for external use.

32.3.7 Proper procurement records are kept to allow tracing.

32.3.8 Acupuncture, Moxibustion, Cupping and other procedures –

There is an appropriate accommodation for patient privacy. The following areas are observed –

- (i) disposable acupuncture needles should not be reused
- (ii) acupuncture needles which are intended to be reused should be properly sterilised before reuse. Appropriate sterilisation

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- should be carried out in accordance with the instructions given by the manufacturer, for example, autoclaving
- (iii) appropriate containers for the disposal of acupuncture needles should be used, for example, sharps boxes. The disposal procedure may make reference from the guidelines promulgated from time to time by the Department of Health
 - (iv) Reusable clinical equipment such as glass cups and derma rollers should be cleaned, disinfected and/or sterilised as appropriate and properly stored
 - (v) personnel responsible for performing sterilisation procedures should be adequately trained
 - (vi) operation of the clinical apparatus should be well maintained and records of periodical inspection should be kept

32.3.9 Investigation

Investigation should be prescribed and carried out by appropriate trained personnel.

32.3.10 Interpretation of investigation results should be carried out by trained personnel.

32.3.11 Where patients are managed by both registered Chinese medicine practitioner and medical practitioner, the treatment plan should be agreed by both parties in consultation with the patient for the best interest of the patients.

32.3.12 The conduct of clinical trial of proprietary Chinese medicine should be in compliance with the guidelines for “Good Clinical Practice for Proprietary Chinese Medicines” issued by the Chinese Medicine Council of Hong Kong.

32.3.13 A notification mechanism of adverse events should be established. If the adverse event is suspected to be associated with the use of Chinese medicine, it should be notified to the Central Notification Office (CENO) of the Centre for Health Protection of the Department of Health.

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Chapter 33 *Satellite Clinic*

33.1 Requirements

- 33.1.1 A medical practitioner, a registered nurse, or a health professional is appointed to be the overall in charge of the clinic.
- 33.1.2 The clinic assistants should work under the supervision of a medical practitioner.
- 33.1.3 The clinic assistants should have received appropriate training. The training received is properly documented.
- 33.1.4 Staff wear badges that identify themselves to the patients.
- 33.1.5 Hand-washing facilities are available in the clinic premises.
- 33.1.6 Scales for fees are displayed in the clinic. Patients are advised of the fees for proposed treatment in advance.
- 33.1.7 There is a record of drugs stored in the clinic.
- 33.1.8 If minor surgery or investigation procedures are undertaken –
- (i) it should take place in a suitably designed and maintained room
 - (ii) a couch is provided
 - (iii) all clinical staff are trained in basic resuscitation
 - (iv) resuscitation equipment is available and checked regularly
- 33.1.9 There are written procedures for –
- (i) dealing with emergencies, including arrangements for transfer to hospital
 - (ii) recording, labelling, appropriate storage and transportation of laboratory specimens
 - (iii) cleansing and sterilisation of equipment
 - (iv) storage and disposal of clinical wastes
- 33.1.10 Where there is provision of x-ray examination for patient, a

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registered radiographer or other qualified health professional is assigned to take charge of the day-to-day operation of the service. There is a warning in both Chinese and English outside the room that houses the x-ray equipment.

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Chapter 34 *Housekeeping and Support Services*

34.1 **Overview**

Properly run housekeeping service, catering service, linen and laundry service, clinical and chemical waste management, storage and supply of medical gases, mortuary service and central sterile supplies service are important to the safe and effective delivery of services to patients.

34.2 **Housekeeping service**

- 34.2.1 Work routines which include schedules of cleansing of the premises and the air-conditioning system are established.
- 34.2.2 Patients' rooms including floors, toilets and bathrooms are cleaned daily and whenever necessary.
- 34.2.3 Common areas such as lobbies, waiting areas, activity rooms are kept clean at all times.
- 34.2.4 Call bells in wards, toilets and bathrooms are kept in order and tested on a regular basis.
- 34.2.5 All cleaning and disinfecting agents are correctly labelled with the product names and different purposes of use as specified by the manufacturer.
- 34.2.6 Pest control is carried out on a regular interval and where necessary.
- 34.2.7 The hospital buildings and compound are kept under proper security control for the safety of patients, visitors and staff and their property. Policies and procedures are in place for handling all incidents and other unexpected happening.
- 34.2.8 When there are renovations or new construction works to be carried out in the hospital, appropriate measures are taken to contain noise and dust.

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34.3 Catering Service

- 34.3.1 If food is served in the establishment, it should be properly prepared according to the needs of patients.
- 34.3.2 All staff who handle food have undertaken regular training in food hygiene.
- 34.3.3 Food handlers are supervised by professional staff such as dietitian or registered nurse.
- 34.3.4 Staff suffering from gastro-enteritis symptoms shall refrain from handling of food until symptoms have subsided.
- 34.3.5 Special diets are provided on the advice of professional staff or a dietitian. There is regular monitoring on the quality of food.
- 34.3.6 Food is provided in different varieties and menus are rotated regularly.
- 34.3.7 The person who is in-charge of the catering service takes reference from the Hazard Analysis Critical Control Point (HACCP) system for ensuring food safety.
- 34.3.8 The kitchen and place for storage of food are kept hygienic to avoid pest infestation.
- 34.3.9 There is a system to label the expiry date of food that has been prepared and stored for serving later.

34.4 Linen and Laundry Services

- 34.4.1 An adequate stock of clean linen is maintained for use.
- 34.4.2 A schedule for the changing of linen is set.
- 34.4.3 There are written policies and procedures on handling of soiled linen, in particular linen of patients suffering from infectious diseases.
- 34.4.4 Linen storage rooms are kept clean and in order.
- 34.4.5 Where laundry service is provided in house, the washers and dryers are regularly maintained.

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- 34.4.6 For occupational safety and health, laundry staff are provided with appropriate personal protective equipment and receive appropriate training on handling of linen / clothing items, chemical detergents and operation of laundry machines.
- 34.4.7 The laundry and related machines, ventilation system of the laundry, etc. are regularly serviced and maintained for effective operations with proper documentation in place.
- 34.4.8 Mechanism exists and documentation is kept to monitor staff performance and quality of services.

34.5 Clinical and Chemical Waste Management

- 34.5.1 Clinical and chemical waste should be handled properly and safely according to written policies and procedures promulgated by the Environmental Protection Department (EPD).
- 34.5.2 A clinical and chemical waste management plan is developed.
- 34.5.3 Clinical waste should be segregated from domestic waste. It should be properly packaged and labelled, using colour-coded bags with biohazard signs. Similarly, all chemical wastes are properly stored and labelled before disposal.
- 34.5.4 Clinical and chemical wastes should be stored securely before collection by specialised waste collectors licensed by the EPD.
- 34.5.5 A record is kept to demonstrate that clinical and chemical wastes have been properly disposed.
- 34.5.6 Staff are provided with appropriate personal protective equipment and receive appropriate training on handling of clinical and chemical wastes.
- 34.5.7 Mechanism exists and documentation is kept to monitor staff performance and quality of services.

34.6 Storage and Supply of Medical Gases

- 34.6.1 The establishment should ensure the safe use of medical gases by taking reference from “The Guidelines in the Supply and Use of Medical Gases in Hospitals and Clinics” issued by the Department

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of Health.

- 34.6.2 Checks on the pipeline systems and the gases emerging from the outlets of pipeline systems must be conducted by a competent engineer when the system is first installed and after it has been repaired, altered, overhauled or extended.
- 34.6.3 A record is maintained of the checks that have been carried out prior to use of a new or repaired system.
- 34.6.4 There are written policies and procedures for recording the delivery, handling and storage of full and empty medical gas cylinders and the details of person in charge of this procedure at each site.
- 34.6.5 The storage of compressed gas cylinders and any liquefied gases must comply with the provisions of the Dangerous Goods Ordinance (Cap 295) and its Regulations.
- 34.6.6 If at any stage, from receipt to use, a compressed gas cylinder is found not to be in a satisfactory condition or without a correct or legible label or an intact seal, it must be rejected. The Department of Health should be notified.
- 34.6.7 A person is appointed to assume overall management of medical gases. Relevant personnel are trained for safe handling of medical gases.

34.7 Mortuary Service

- 34.7.1 There are written policies and procedures for proper identification and safe transfer of a deceased patient from the ward or other area in the hospital to the mortuary and subsequent handover of dead body to the deceased's family and undertaker.
- 34.7.2 The mortuary and plant should be regularly inspected and maintained. The temperature of the cold chamber(s) is monitored and recorded at regular intervals.
- 34.7.3 Staff are provided with appropriate personal protective equipment and receive appropriate training on safe handling of dead body

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34.8 Central Sterile Supplies Service

- 34.8.1 Staff receive appropriate training in the handling and use of sterile supplies.
- 34.8.2 The service is carried out in line with the infection control policy of the hospital / establishment.
- 34.8.3 Sterile supplies are delivered in appropriate carriers and stored in a clean and dry area.
- 34.8.4 All sterilising equipment are regularly inspected and maintained. Relevant staff are appropriately trained in the use of the equipment.
- 34.8.5 The stock levels of sterile supplies are checked regularly and correctly rotated.
- 34.8.6 Measures are taken to ensure the effectiveness of sterilisation.
- 34.8.7 There is proper documentation of different batches of sterilised supplies so that recall of sterilised products with problem can be carried out effectively for remedial action.

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Appendix 1

The applicant should approach the relevant government departments to ascertain whether the operation of the establishment including the use of the premises is in compliance with relevant Ordinances and Regulations of the Laws of Hong Kong. Examples include but not limited to the following –

Government Department	Relevant Ordinances
Buildings Department	· Buildings Ordinance (Cap 123)
Electrical and Mechanical Services Department	· Electricity Ordinance (Cap 406) · Lifts and Escalators Ordinance (Cap 618) · Gas Safety Ordinance (Cap 51)
Environmental Protection Department	· Air Pollution Control Ordinance (Cap 311) · Noise Control Ordinance (Cap 400) · Wastes Disposal Ordinance (Cap 354) · Water Pollution Control Ordinance (Cap 358)
Fire Services Department	· Fire Services Ordinance (Cap 95) · Fire Safety (Buildings) Ordinance (Cap 572) · Fire Safety (Commercial Premises) Ordinance (Cap 502) · Dangerous Goods Ordinance (Cap 295)
Lands Department	· Land Registration Ordinance (Cap 128) · Land Titles Ordinance (Cap 585)
Planning Department	· Town Planning Ordinance (Cap 131)
Water Supplies Department	· Waterworks Ordinance (Cap 102)

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Apart from the above Ordinances, upon grant of the licence, the licensee and the Board of Governors should also ensure that the relevant Ordinances and Laws of Hong Kong are adhered to during daily operation. The following list of Ordinances is not exhaustive and is meant for the licensee's reference only.

Government Department/ Statutory Body	Relevant Ordinances
Department of Health	<ul style="list-style-type: none"> · Dangerous Drugs Ordinance (Cap 134) · Antibiotics Ordinance (Cap 137) · Pharmacy and Poisons Ordinance (Cap 138) · Prevention and Control of Disease Ordinance (Cap 599) · Radiation Ordinance (Cap 303) · Smoking (Public Health) Ordinance (Cap 371) · Undesirable Medical Advertisement Ordinance (Cap 231)
Council on Human Reproductive Technology	<ul style="list-style-type: none"> · Human Reproductive Technology Ordinance (Cap 561)
Human Organ Transplant Board	<ul style="list-style-type: none"> · Human Organ Transplant Ordinance (Cap 465)
Medical Council of Hong Kong	<ul style="list-style-type: none"> · Medical Registration Ordinance (Cap 161)
Chinese Medicine Council of Hong Kong	<ul style="list-style-type: none"> · Chinese Medicine Ordinance (Cap 549)
Dental Council of Hong Kong	<ul style="list-style-type: none"> · Dentist Registration Ordinance (Cap 156)
The Nursing Council of Hong Kong	<ul style="list-style-type: none"> · Nurses Registration Ordinance (Cap 164)
The Midwives Council of Hong Kong	<ul style="list-style-type: none"> · Midwives Registration Ordinance (Cap 162)

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**Government
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Statutory Body**

Relevant Ordinances

- Supplementary Medical Professions Council · Supplementary Medical Professions Ordinance (Cap 359)
- Food and Environmental Hygiene Department · Public Health and Municipal Services Ordinance (Cap 132)
- Independent Commission Against Corruption · Independent Commission Against Corruption Ordinance (Cap 204)
- Prevention of Bribery Ordinance (Cap 201)
- Judiciary · Coroners Ordinance (Cap 504)
- Labour Department · Employment Ordinance (Cap 57)
- Employee's Compensation Ordinance (Cap 282)
- Occupational Safety and Health Ordinance (Cap 509)
- Boilers and Pressure Vessels Ordinance (Cap 56)
- Mandatory Provident Fund Schemes Authority · Mandatory Provident Fund Schemes Ordinance (Cap 485)
- Occupational Retirement Schemes Ordinance (Cap 426)
- Office of the Privacy Commissioner for Personal Data, Hong Kong · Personal Data (Privacy) Ordinance (Cap 486)
- Social Welfare Department · Drug Dependent Persons Treatment and Rehabilitation Centres (Licensing) Ordinance (Cap 566)

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