



LAGOS STATE HEALTH FACILITY MONITORING AND ACCREDITATION AGENCY

FACILITY INSPECTION TOOL FOR PHCS

These standards and tools were developed in partnership
with PharmAccess and are based on SafeCare principles.

MARCH 1, 2017

HEALTH FACILITY MONITORING AND ACCREDITATION AGENCY (HEFAMAA) ASSESSMENT TOOL

Name of Establishment	
Full Address	
Ward	
Local Government Area	
Status of Establishment	New <input type="checkbox"/> Existing <input type="checkbox"/>
HEFAMAA Reg. Number	
Contact details of Establishment (Name, email, phone)	
Days and hours of operation	
Name and designation of person(s) interviewed	
Name of HEFAMAA Officer(s) <i>Include designation</i>	
Date of Assessment: <hr style="width: 200px; margin-left: 0;"/> <div style="text-align: center;">Day/Month/Year</div>	Arrival time for Assessment __ __ : __ __ <div style="text-align: center;">H H M M</div> Departure time after Assessment __ __ : __ __ <div style="text-align: center;">H H M M</div>

Type of Health Establishment

Public Comprehensive HC <input type="checkbox"/>	Public PHC <input type="checkbox"/>	Private Clinic/HC <input type="checkbox"/>
Convalescent/Nursing Home <input type="checkbox"/>	Maternity Home <input type="checkbox"/>	Private Hospital <input type="checkbox"/>
Others, please specify _____		

Other Branches:

Any branch(es):	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes, specify Number _____ and location(s):		
i.	_____	
ii.	_____	
iii.	_____	
iv.	_____	
v.	_____	

A. Services Provided

Primary Healthcare Services <input type="checkbox"/> <i>Tick the box and use this tool if the facility provides primary health care services only</i>		
Child Welfare & Immunization <input type="checkbox"/>	Skilled birth delivery <input type="checkbox"/>	
General Medical Practice <input type="checkbox"/>	Family planning <input type="checkbox"/>	
HIV prevention (HCT & PMTCT) <input type="checkbox"/>	TB/DOTS <input type="checkbox"/>	
Specify Services provided: _____		
Clinical Support services:		
Laboratory <input type="checkbox"/>	Ultrasound <input type="checkbox"/>	Pharmaceutical <input type="checkbox"/>
Others specify _____		

B. Ownership, Governance and Registration Status

1. Type of Ownership		
Public <input type="checkbox"/>	Private <input type="checkbox"/>	Public Private Partnership <input type="checkbox"/>
Others Specify _____		
2. If private, what is the ownership arrangement		
Sole proprietorship <input type="checkbox"/>	Group practice <input type="checkbox"/>	Limited Liability company <input type="checkbox"/>
3. Governance Structure		
Is there an organogram?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. CAC Registration Status		
Registered <input type="checkbox"/>	Registration in progress <input type="checkbox"/>	Not registered <input type="checkbox"/>
5.		
Ever Registered <input type="checkbox"/>	Registration in progress <input type="checkbox"/>	Not registered <input type="checkbox"/>
6. HEFAMAA Renewal Status		
Up to date <input type="checkbox"/>	Not up to date <input type="checkbox"/>	Last year of renewal _____
Comment:		

C. Building and Designated Areas

7. Type of Building		
Purpose built <input type="checkbox"/>	Stand alone <input type="checkbox"/>	Shared accommodation <input type="checkbox"/>
Specify type of Building		
Other, please specify _____		

Please note that the surface area of these rooms must not be less than 4 by 3 square meters

Room	Adequate in size	Well-equipped
8. Waiting/Reception Area	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Consulting Room Area <i>Specify number of consulting rooms</i> _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Treatment Room Area	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Wards	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. Labour Room	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
13. Ventilation	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
14. Lighting	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
15. Painting	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
Comment:		

D. Observation/Inpatient Care

16. Does this facility provide inpatient care	Yes <input type="checkbox"/>	No <input type="checkbox"/>
17. If yes, please specify the number of beds	_____	
18. If no, please specify the number of observation beds	_____	
19. No. of Beds (<i>indicate number</i>)	Functional _____	Non-functional _____
20. One metre space between beds	Yes <input type="checkbox"/>	No <input type="checkbox"/>
21. Mattresses and Pillows	Functional <input type="checkbox"/>	Not functional <input type="checkbox"/>
Covered with mackintosh	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Comment:		

E. Maternity Unit

22. Delivery bed with stirrups (<i>Specify number</i>):_____	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
23. Angle Poise Lamp (<i>Specify number</i>):_____	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
24. Resuscitaire (<i>Specify number</i>):_____	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
(Includes: Mucus extractor, Ambu Bag, Flat Table, Lamp)		
25. Suction machine		
Manual (<i>Specify number</i>):_____	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
Automatic (<i>Specify Number</i>):_____	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
26. Suturing materials	Available <input type="checkbox"/>	Not Available <input type="checkbox"/>

27. Oxygen (tick the applicable - sighted)		Available <input type="checkbox"/>	Not Available <input type="checkbox"/>
a. Cylinder with all accessories (Gauge, Flow Meter, Masks, tubes)		<input type="checkbox"/>	
b. Oxygen concentrator		<input type="checkbox"/>	
28. Pinard Fetoscope	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sonicaid	Yes <input type="checkbox"/> No <input type="checkbox"/>
29. Does the facility possess the following maternal life-saving drugs and commodities?			
Magnesium sulphate	Yes <input type="checkbox"/> No <input type="checkbox"/>	Misoprostol	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anti-shock garment	Yes <input type="checkbox"/> No <input type="checkbox"/>		
30. Delivery packs are available (minimum of 3) see Annex 2		Yes <input type="checkbox"/> No <input type="checkbox"/>	
31. Baby cots Specify number functional: _____		Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
32. Infant ID bracelets are available		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Comment			

F. Emergency and Referral Services

33. Clinical and nursing personnel are trained on BLS	Yes <input type="checkbox"/> No <input type="checkbox"/>
34. Facility has skilled personnel trained on MNCH related emergencies (use of partograph, anti-shock garment, misoprostol and Mag. Sulphate)	Yes <input type="checkbox"/> No <input type="checkbox"/>
35. Emergency equipment are available and functional	Yes <input type="checkbox"/> No <input type="checkbox"/>
Oxygen cylinder /concentrator <input type="checkbox"/>	Ambubag Paediatric <input type="checkbox"/> Ambubag Adult <input type="checkbox"/>
Suction machine <input type="checkbox"/>	Nebulizer <input type="checkbox"/> Defibrillator <input type="checkbox"/>
36. Contents of Emergency Tray	Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/>
<i>(check functionality (Good or Bad) and expiry) – see Annex 1 for List</i>	
List of emergency equipment and commodities sighted and functionality (Good or Bad) and expired	
i.	ii.
iii.	iv.
v.	vi.
vii.	viii.
ix.	x.
37. Is there an established referral system in place?	Yes <input type="checkbox"/> No <input type="checkbox"/>
38. Are ambulance services readily accessible?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Comment	

G. Sterilization / Infection Control

39. Designated sterilization area	Available <input type="checkbox"/>	Not Available <input type="checkbox"/>
40. Functional Autoclave	Yes <input type="checkbox"/>	No <input type="checkbox"/>
41. Sterilization Drum	Yes <input type="checkbox"/>	No <input type="checkbox"/>
42. Use of indicator tape	Yes <input type="checkbox"/>	No <input type="checkbox"/>
43. Other methods (please describe): _____		
44. Personal protective devices (Head Cap, Eye Goggles, Face Mask, Apron, Surgical Gloves, Latex Gloves, Elbow Length Gloves, Industrial Gloves, Knee Length Boots, Ankle length Boots) Others (Specify): _____	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
Comment		

H. Hand Washing Facilities

Check adequacy of handwashing facilities: <i>Water supply, liquid soap (with manual applicator), drying technique (single-use hand towels)</i>		
45. Treatment Room	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
46. Consulting Room	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
47. Wards	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
48. Health Records	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
49. Labour room	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
50. Laboratory	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
Comment:		

I. Health Records

51. Indicate if records are	Paper-based <input type="checkbox"/>	Digital <input type="checkbox"/>	Both <input type="checkbox"/>
Describe if it is both _____			
52. Are records facilities adequate:			
Secure Location	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Shelving	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Filing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
53. Are NHMIS registers available	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
54. Is HMIS data submitted monthly	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Comment:			

J. Diagnostic Services

Laboratory

55. Type of Laboratory: Commercial (standalone) <input type="checkbox"/> Hospital Lab <input type="checkbox"/> Side Lab <input type="checkbox"/>											
56. Laboratory investigations (<i>Specify tests</i>) <table border="0"><tr><td><i>i.</i></td><td><i>ii.</i></td></tr><tr><td><i>iii.</i></td><td><i>iv.</i></td></tr><tr><td><i>v.</i></td><td><i>vi.</i></td></tr><tr><td><i>vii.</i></td><td><i>viii.</i></td></tr><tr><td><i>ix.</i></td><td><i>x.</i></td></tr></table>		<i>i.</i>	<i>ii.</i>	<i>iii.</i>	<i>iv.</i>	<i>v.</i>	<i>vi.</i>	<i>vii.</i>	<i>viii.</i>	<i>ix.</i>	<i>x.</i>
<i>i.</i>	<i>ii.</i>										
<i>iii.</i>	<i>iv.</i>										
<i>v.</i>	<i>vi.</i>										
<i>vii.</i>	<i>viii.</i>										
<i>ix.</i>	<i>x.</i>										
57. Personnel in Charge: Pathologist <input type="checkbox"/> Med Lab Scientist <input type="checkbox"/> Med Lab Tech <input type="checkbox"/> Others-please specify: _____											
58. Lab Equipment (<i>adequacy based on scope of services</i>) Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/> List lab equipment sighted and functionality (<i>Good or Bad</i>) <table border="0"><tr><td><i>i.</i></td><td><i>ii.</i></td></tr><tr><td><i>iii.</i></td><td><i>iv.</i></td></tr><tr><td><i>v.</i></td><td><i>vi.</i></td></tr><tr><td><i>vii.</i></td><td><i>viii.</i></td></tr><tr><td><i>ix.</i></td><td><i>x.</i></td></tr></table>		<i>i.</i>	<i>ii.</i>	<i>iii.</i>	<i>iv.</i>	<i>v.</i>	<i>vi.</i>	<i>vii.</i>	<i>viii.</i>	<i>ix.</i>	<i>x.</i>
<i>i.</i>	<i>ii.</i>										
<i>iii.</i>	<i>iv.</i>										
<i>v.</i>	<i>vi.</i>										
<i>vii.</i>	<i>viii.</i>										
<i>ix.</i>	<i>x.</i>										
59. Power Supply	Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/>										
60. Waste Management	Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/>										
61. Illumination	Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/>										
62. Water Supply	Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/>										
63. PPE	Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/>										
Comment: 											

Ultrasound Services

64. Does the facility provide ultrasound services	Yes <input type="checkbox"/>	No <input type="checkbox"/>
65. Who provides ultrasound services: Radiologist <input type="checkbox"/> Sonographer <input type="checkbox"/> Sonologist <input type="checkbox"/> Others, please specify _____		
Comment 		

K. Medication Management

66. Is there a functional pharmacy or dispensary	Yes <input type="checkbox"/>	No <input type="checkbox"/>
67. Specify if it is a pharmacy or dispensary	<hr/>	
68. Indicate Personnel in Charge:	Pharmacist <input type="checkbox"/>	Pharm. Technician <input type="checkbox"/>
69. Is there a Counselling Area	Yes <input type="checkbox"/>	No <input type="checkbox"/>
70. Is there a Compounding Area	Yes <input type="checkbox"/>	No <input type="checkbox"/>
71. Is the size of the dispensing room adequate (Minimum of 30m ²)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
72. Well arranged with adequate ventilation (Adequate shelves and pallets)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
73. Illumination	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
74. Is there a Drug Formulary (EMDEX, BNF etc)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
75. Room temperature charts are available	Yes <input type="checkbox"/>	No <input type="checkbox"/>
76. Is there a functional fridge	Yes <input type="checkbox"/>	No <input type="checkbox"/>
77. Are Fridge temperature charts available (Including for Vaccines)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
78. Is there a lockable DDA cupboard and register	Yes <input type="checkbox"/>	No <input type="checkbox"/>
79. Disposal of expired drugs and consumables	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
80. Appropriate use of PPEs	Yes <input type="checkbox"/>	No <input type="checkbox"/>
81. Availability of Fire Fighting equipment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Comment:		

L. Catering Services

82. Are catering services provided	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes,	In-house <input type="checkbox"/>	Outsourced <input type="checkbox"/>
83. Is the kitchen clean (Walls, floor, utensils, extractor, door with net, pest control)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
84. Is the kitchen well-ventilated	Yes <input type="checkbox"/>	No <input type="checkbox"/>
85. Is the kitchen well equipped (check cooking equipment, utensils, storage of perishable and non-perishable food, refrigeration)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
86. Fire blanket and fire extinguisher sighted	Yes <input type="checkbox"/>	No <input type="checkbox"/>
87. Fire Alarm is available and functional	Yes <input type="checkbox"/>	No <input type="checkbox"/>
88. Evidence of food handlers test (Salmonella, Staph Aureus, TB, HBsAg, Stool Test)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Comment:		

M. Environment and Amenities

89. General Ventilation	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
90. Illumination	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
91. Main source of electricity	PHCN <input type="checkbox"/>	Others <input type="checkbox"/>
<i>Other, please specify</i> _____		
92. Is there alternate power supply	Yes <input type="checkbox"/>	No <input type="checkbox"/>
93. If yes, tick applicable option(s)	Generator <input type="checkbox"/>	Inverter <input type="checkbox"/> Solar <input type="checkbox"/>
<i>Others sources, please specify</i> _____		
94. Is there potable water supply	Yes <input type="checkbox"/>	No <input type="checkbox"/>
95. Source(s) of water	Pipe borne <input type="checkbox"/> Borehole <input type="checkbox"/> Well <input type="checkbox"/> Vendor <input type="checkbox"/> Others _____	
96. No of Toilets	Available: _____	Functional: _____
<i>Cistern that flushes</i>		
97. Number of toilets available for staff	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
98. Number of toilets for OPD	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
99. Number of toilets for Inpatients	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
100. Wash hand basin with running water	Yes <input type="checkbox"/>	No <input type="checkbox"/>
101. Cleaning agents and disinfectant sighted	Yes <input type="checkbox"/>	No <input type="checkbox"/>
102. Anti-bacterial hand wash	Yes <input type="checkbox"/>	No <input type="checkbox"/>
103. Toilet roll	Yes <input type="checkbox"/>	No <input type="checkbox"/>
104. Pedal bin lined with nylon	Yes <input type="checkbox"/>	No <input type="checkbox"/>
105. Serviette/Single-use hand towel	Yes <input type="checkbox"/>	No <input type="checkbox"/>
106. Shower with running water	Yes <input type="checkbox"/>	No <input type="checkbox"/>
107. Is there external drainage (gutter)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
108. Is the drainage covered	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Comments:		

Waste Management

Registered with:		
109. LAWMA PSP	Yes <input type="checkbox"/>	No <input type="checkbox"/>
110. LAWMA Medical	Yes <input type="checkbox"/>	No <input type="checkbox"/>
111. Correct bin and sharps container used	Yes <input type="checkbox"/>	No <input type="checkbox"/>
112. Proper waste segregation observed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
113. Use of appropriate coloured bags	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>(Tick those available)</i>		
Black <input type="checkbox"/>	Yellow <input type="checkbox"/>	Red <input type="checkbox"/> Brown <input type="checkbox"/> Safety sharp box <input type="checkbox"/>
114. Final collection point	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>

115. Domestic Waste management	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
116. Medical Waste management	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
Comment:		

N. Fire Safety

117. Fire Service Certification	Available <input type="checkbox"/>	Not Available <input type="checkbox"/>
118. Fire-fighting equipment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
119. Service History	Yes <input type="checkbox"/>	No <input type="checkbox"/>
120. Two readily accessible and labelled exits seen	Yes <input type="checkbox"/>	No <input type="checkbox"/>
121. Muster/Assembly Point	Available <input type="checkbox"/>	Not Available <input type="checkbox"/>
Comment:		

O. Staffing

122. Facility has a Quality Improvement Program	Yes <input type="checkbox"/>	No <input type="checkbox"/>
123. Regular update training for health personnel	Yes <input type="checkbox"/>	No <input type="checkbox"/>
124. Duty Roster for health personnel available	Yes <input type="checkbox"/>	No <input type="checkbox"/>
125. Adequate number of qualified health personnel	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If No, state the personnel type _____		

Health Centre *(Indicate number of personnel)*

Staff:			
Full Time:		Part Time:	
Doctors		Doctors	
Nurses		Nurses	
Others		Others	

Maternity Centre

1. No. of visits by the Doctors per week.....
2. No. of first stage/Labour room beds.....
3. No of beds in lying in ward.....
4. No of cots.....

Nursing/Convalescent Home

5. No. of visit by Doctor per week.....
6. Hours of consultation.....

STAFF COMPLEMENT FORM

S/N	Name	MDCN Reg. No & Date	Designation (Consultant, MO	Specialty (If any)
Medical Doctor				
Nurse				
S/N	Name	NMCN Reg. No & date	Staff Nurse/Midwife	Specialty (If any)
Pharmacist				
S/N	Name	Reg. No. & Date		
Laboratory personnel				
Others				

Annex 1: Standard Emergency Tray List

Resuscitation Equipment

1. Pocket mask with 1-way valve (1)
2. Disposable airways
 - Adult Size (2)
 - Child Size (2)
 - Infant Size (2)
3. Adult and Paediatric Ambu bag

Evaluation Equipment

1. Blood pressure cuff – Adult (1)
2. Blood pressure cuff – Paediatric (1)
3. Manometer appropriate for both cuffs (1)
4. Stethoscope (1)

Treatment Equipment

1. Tourniquet (2)
2. Alcohol wipes (15)
3. Syringes – disposable
4. 3 cc with 20 g 1 ½ inch needle (5)
5. 1 cc TB with 25 g 5/8 inch needle (5)
6. 4x4s (one box)
7. Band-Aids (one box)
8. Adhesive tape (one roll)
9. IV solutions (LR, NS)
10. IV tubing (2)
11. Angiocaths (assorted)

Drugs

1. Epinephrine – 1:1000 1cc ampoule (5)
2. Benadryl – 50 mg/cc 10 ml multi-dose vial (1)
3. Atropine – 1 mg ampoule (1)
4. Oxygen tank, wrench and tubing (1)
5. Hydrocortisone 100mg ampoule (2)

Annex 2: Sterile Delivery Pack

1. Mayo scissors
2. 1L & 700ml Kidney dish
3. Spencer Wells forceps x2
4. Sterile Syringe 25ml
5. Cord clamp
6. Combines 10x20cm x2
7. Baby Wrap
8. Baby name tag
9. Needle - 18g x2, Needle - 23g x2
10. Gauze swabs x2
11. Abdominal sponges x5
12. Galley pot graduated 10-150ml x 2
13. Trolley cover/outer wrap x 1
14. Catheter pack: Foley's 12FG catheter, 20ml syringe, urine bag, water for injection, tape
15. Protective glasses
16. Gloves - Sterile (size: 6, 7, 8) x2
17. Gown/Apron - disposable, non-sterile