



LAGOS STATE HEALTH FACILITY MONITORING AND ACCREDITATION AGENCY

FACILITY INSPECTION TOOL (SECONDARY LEVEL)

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: 50%; 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

General Hospital (Public) <input type="checkbox"/>	Private Hospital <input type="checkbox"/>	Private Clinic <input type="checkbox"/>
Mono-specialist Hospital <input type="checkbox"/> (e.g. Dialysis, Cardiac Centres)	Mono-Specialist Clinic <input type="checkbox"/> (e.g. Dental, Optical Clinic)	Diagnostic Centre <input type="checkbox"/>
Others, please specify _____		

Other Branches:

Any other 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

Tick appropriate box(es). Use this tool if the facility provides primary and secondary health services		
Primary Healthcare Services	<input type="checkbox"/>	
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: _____		
Secondary/Specialist Care Services <input type="checkbox"/> (e.g. Internal Medicine, Paediatrics, Obstetrics & gynaecology, Surgery etc)		
Specify specialist care services provided: _____		

Surgeries (tick applicable, multiple options allowed and specify for intermediate and major)		
Minor	<input type="checkbox"/>	Intermediate <input type="checkbox"/> Major <input type="checkbox"/>
Intermediate _____		
Major _____		
Clinical Support services:		
Laboratory	<input type="checkbox"/>	Ultrasound <input type="checkbox"/> X-ray <input type="checkbox"/>
CT scan	<input type="checkbox"/>	MRI <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"/>
Other 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. HEFAMAA Registration Status		
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. No of Beds (<i>indicate number</i>)	Functional _____	Non-functional _____
19. One metre space between beds	Yes <input type="checkbox"/>	No <input type="checkbox"/>
20. 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

21. Delivery bed with stirrups (Specify number):____	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
22. Angle Poise Lamp (Specify number):____	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
23. Resuscitaire (Specify number):____ (Includes: Mucus extractor, Ambu Bag, Flat Table, Lamp)	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
24. Incubator (Specify number):____	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
25. Suction machine Manual (Specify number):____	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
26. Automatic (Specify Number):____	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
27. Suturing materials	Available <input type="checkbox"/>	Not Available <input type="checkbox"/>
28. 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"/>	
29. Pinard Fetoscope	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sonicaid Yes <input type="checkbox"/> No <input type="checkbox"/>
30. 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"/>
31. Anti-shock garment	Yes <input type="checkbox"/> No <input type="checkbox"/>	
32. Delivery packs are available (see Annex 2 and is number adequate for deliveries?)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
33. Baby cots Specify number functional:_____	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
34. Infant ID bracelets are available	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Comment		

F. Operating Theatre

35. Size (Please Specify) _____sq.m	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
36. Temperature/ Humidity Control	Appropriate <input type="checkbox"/>	Inappropriate <input type="checkbox"/>
37. Scrub Facilities	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
38. Changing Area	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
39. Red Line area	Yes <input type="checkbox"/>	No <input type="checkbox"/>
40. Anaesthetic machine	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
41. Anaesthetic Gas	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
42. Suction machine	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
43. Theatre Bed	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
44. Adjustable theatre Light	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
45. Oxygen (tick the applicable - sighted)	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
Cylinder with all accessories (Gauge, Flow Meter, Masks, tubes)	<input type="checkbox"/>	
Oxygen concentrator	<input type="checkbox"/>	

46. Defibrillator	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
47. Resuscitation tray (check ambubag, airway, drugs and consumables)	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
48. Resuscitaire (Specify number):____ (Includes: Mucus extractor, Ambu Bag, Flat Table, Lamp)	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>
49. Lighting	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
50. Flooring	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
51. Walls	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
52. Recovery Room (see annex 2)	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
Comment		

G. Emergency and Referral Services

53. Clinical and nursing personnel are trained on BLS	Yes <input type="checkbox"/>	No <input type="checkbox"/>										
54. 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"/>										
55. 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"/>											
56. Contents of Emergency Tray (check functionality (Good or Bad) and expiry) – see Annex 3 for List	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>										
<p>List of emergency equipment and commodities sighted and functionality (Good or Bad) and expired</p> <table border="0"> <tr> <td>i.</td> <td>ii.</td> </tr> <tr> <td>iii.</td> <td>iv.</td> </tr> <tr> <td>v.</td> <td>vi.</td> </tr> <tr> <td>vii.</td> <td>viii.</td> </tr> <tr> <td>ix.</td> <td>x.</td> </tr> </table>			i.	ii.	iii.	iv.	v.	vi.	vii.	viii.	ix.	x.
i.	ii.											
iii.	iv.											
v.	vi.											
vii.	viii.											
ix.	x.											
57. Is there an established referral system in place?	Yes <input type="checkbox"/>	No <input type="checkbox"/>										
58. Are ambulance services readily accessible?	Yes <input type="checkbox"/>	No <input type="checkbox"/>										
Comment												

H. Sterilization / Infection Control

59. CSSD	Available <input type="checkbox"/>	Not Available <input type="checkbox"/>
60. Scrub Room	Available <input type="checkbox"/>	Not Available <input type="checkbox"/>
61. Functional Autoclave	Yes <input type="checkbox"/>	No <input type="checkbox"/>
62. Sterilization Drum	Yes <input type="checkbox"/>	No <input type="checkbox"/>
63. Use of indicator tape	Yes <input type="checkbox"/>	No <input type="checkbox"/>
64. Other methods (please describe): _____		
65. 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		

I. Hand Washing Facilities

Check adequacy of handwashing facilities: <i>Water supply, liquid soap(with manual applicator), drying technique (single-use hand towels)</i>		
66. Treatment Room	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
67. Consulting Room(s)	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
68. Wards	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
69. Health Records	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
70. Labour room	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
71. Laboratory	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
Comment:		

J. Health Records

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

K. Diagnostic Services**Laboratory**

78. Type of Laboratory: Commercial (standalone) <input type="checkbox"/> Hospital Lab <input type="checkbox"/> Side Lab <input type="checkbox"/>											
79. Laboratory investigations (<i>Specify tests</i>) <table><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>										
80. Personnel in Charge: Pathologist <input type="checkbox"/> Med Lab Scientist <input type="checkbox"/> Med Lab Tech <input type="checkbox"/> Others-please specify: _____											
81. 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><tr><td><i>xi.</i></td><td><i>xii.</i></td></tr><tr><td><i>xiii.</i></td><td><i>xiv.</i></td></tr><tr><td><i>xv.</i></td><td><i>xvi.</i></td></tr><tr><td><i>xvii.</i></td><td><i>xviii.</i></td></tr><tr><td><i>xix.</i></td><td><i>xx.</i></td></tr></table>		<i>xi.</i>	<i>xii.</i>	<i>xiii.</i>	<i>xiv.</i>	<i>xv.</i>	<i>xvi.</i>	<i>xvii.</i>	<i>xviii.</i>	<i>xix.</i>	<i>xx.</i>
<i>xi.</i>	<i>xii.</i>										
<i>xiii.</i>	<i>xiv.</i>										
<i>xv.</i>	<i>xvi.</i>										
<i>xvii.</i>	<i>xviii.</i>										
<i>xix.</i>	<i>xx.</i>										
82. Power Supply	Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/>										
83. Waste Management	Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/>										
84. Illumination	Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/>										
85. Water Supply	Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/>										
86. PPE	Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/>										
Comment: 											

Ultrasound Services

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

X-Ray

89. Scope of Services:		X-ray only <input type="checkbox"/>	Contrast studies <input type="checkbox"/>
90. X Ray machine		Digital <input type="checkbox"/>	Manual <input type="checkbox"/>
Age of Machine: _____ years			
91. Evidence of radiation safety inspection report By Nigeria Nuclear Regulatory Agency (NNRA)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
92. Lead lined walls	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
93. X-ray proof doors	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
94. Well calibrated X-ray machine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
95. Registration with radioactive waste disposal entity	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
96. Warning Indicator Light	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Personal Protective devices available:			
97. Lead jacket or apron	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Others: Thyroid shield <input type="checkbox"/>	Gonads shield <input type="checkbox"/>	Optical shield <input type="checkbox"/>	
Thermolumiscent Dosimeter (TLD) Badge	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
98. If available, is the TLD badge	Functional <input type="checkbox"/>	Non-functional <input type="checkbox"/>	
<i>Specify date of last reading of TLD badge] _____ and expiry date _____</i>			
99. Personnel in Charge: Radiologist <input type="checkbox"/> Radiographer <input type="checkbox"/> X-ray technician <input type="checkbox"/>			
Others-please specify: _____			
Comment: 			

L. Medication Management

100. Is there a functional pharmacy or dispensary	Yes <input type="checkbox"/>	No <input type="checkbox"/>
101. Specify if it is a pharmacy or dispensary _____		
102. Indicate Personnel in Charge:	Pharmacist <input type="checkbox"/>	Pharm. Technician <input type="checkbox"/>
103. Is there a Counselling Area	Yes <input type="checkbox"/>	No <input type="checkbox"/>
104. Is there a Compounding Area	Yes <input type="checkbox"/>	No <input type="checkbox"/>
105. Is the size of the dispensing room adequate (Minimum of 30m²)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
106. Well arranged with adequate ventilation (Adequate shelves and pallets)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
107. Illumination	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
108. Is there a Drug Formulary (EMDEX, BNF etc)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
109. Room temperature charts are available	Yes <input type="checkbox"/>	No <input type="checkbox"/>

110. Is there a functional fridge	Yes <input type="checkbox"/>	No <input type="checkbox"/>
111. Are Fridge temperature charts available (Including for Vaccines)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
112. Is there a lockable DDA cupboard and register	Yes <input type="checkbox"/>	No <input type="checkbox"/>
113. Disposal of expired drugs and consumables	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
114. Appropriate use of PPEs	Yes <input type="checkbox"/>	No <input type="checkbox"/>
115. Availability of Fire Fighting equipment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Comment:		

M. Catering Services

116. Are catering services provided	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes,	In-house <input type="checkbox"/>	Outsourced <input type="checkbox"/>
117. Is the kitchen clean (Walls, floor, utensils, extractor, door with net, pest control)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
118. Is the kitchen well-ventilated	Yes <input type="checkbox"/>	No <input type="checkbox"/>
119. 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"/>
120. Fire blanket and fire extinguisher sighted	Yes <input type="checkbox"/>	No <input type="checkbox"/>
121. Fire Alarm is available and functional	Yes <input type="checkbox"/>	No <input type="checkbox"/>
122. Evidence of food handlers test (Salmonella, Staph Aureus, TB, HBsAg, Stool Test)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Comment:		

N. Environment and Amenities

123. General Ventilation	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
124. Illumination	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
125. Power Source	National Grid <input type="checkbox"/>	Others <input type="checkbox"/>
126. Is there alternate power supply	Yes <input type="checkbox"/>	No <input type="checkbox"/>
127. Is there potable water supply	Yes <input type="checkbox"/>	No <input type="checkbox"/>
128. Source of water		
Pipe borne <input type="checkbox"/> Borehole <input type="checkbox"/> Well <input type="checkbox"/> Vendor <input type="checkbox"/>		
Others _____		
129. No of Toilets	Available: _____	Functional: _____
<i>Cistern that flushes</i>		
130. Wash hand basin with running water	Yes <input type="checkbox"/>	No <input type="checkbox"/>
131. Cleaning agents and disinfectant sighted	Yes <input type="checkbox"/>	No <input type="checkbox"/>
132. Anti-bacterial hand wash	Yes <input type="checkbox"/>	No <input type="checkbox"/>
133. Toilet roll	Yes <input type="checkbox"/>	No <input type="checkbox"/>
134. Pedal bin lined with nylon	Yes <input type="checkbox"/>	No <input type="checkbox"/>
135. Serviette/Single-use hand towel	Yes <input type="checkbox"/>	No <input type="checkbox"/>
136. Shower with running water	Yes <input type="checkbox"/>	No <input type="checkbox"/>
137. Is there external drainage (gutter)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
138. Is the drainage covered	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Comments:		

O. Waste Management

Registered with:		
139. LAWMA PSP	Yes <input type="checkbox"/>	No <input type="checkbox"/>
140. LAWMA Medical	Yes <input type="checkbox"/>	No <input type="checkbox"/>
141. Correct bin and sharps container used	Yes <input type="checkbox"/>	No <input type="checkbox"/>
142. Proper waste segregation observed	Yes <input type="checkbox"/>	No <input type="checkbox"/>
143. 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"/>	
144. Final collection point	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
145. Domestic Waste management	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
146. Medical Waste management	Adequate <input type="checkbox"/>	Inadequate <input type="checkbox"/>
Comment:		

P. Fire Safety

147. Fire Registration Status	Registered <input type="checkbox"/>	Not Registered <input type="checkbox"/>
148. Fire-fighting equipment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
149. Service History	Yes <input type="checkbox"/>	No <input type="checkbox"/>
150. Two readily accessible and labelled exits seen	Yes <input type="checkbox"/>	No <input type="checkbox"/>
151. Muster/Assembly Point	Available <input type="checkbox"/>	Not Available <input type="checkbox"/>

Q. Staffing

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

Number of Staff

Obtain staffing list – Full-time and Part-time

Cadre	Full-time	Part-time
Doctors		
Nurses		
Pharmacists		
Pharm. Technicians		
Lab scientists		
Lab technicians		
Lab assistants		
Others		

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: 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

Annex 2: Recovery Room

1. Hospital Bed – adjustable for positioning of recovery patients
2. Defibrillator
3. Pulse Oximeter
4. Emergency tray (see list in Annex 3)
5. Oxygen concentrator or cylinder with accessories
6. BP meter
7. Thermometer

Annex 3: 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

18. Mayo scissors
19. 1L & 700ml Kidney dish
20. Spencer Wells forceps x2
21. Sterile Syringe 25ml
22. Cord clamp
23. Combines 10x20cm x2
24. Baby Wrap
25. Baby name tag
26. Needle - 18g x2, Needle - 23g x2
27. Gauze swabs x2
28. Abdominal sponges x5
29. Galley pot graduated 10-150ml x 2
30. Trolley cover/outer wrap x 1
31. Catheter pack: Foley's 12FG catheter, 20ml syringe, urine bag, water for injection, tape
32. Protective glasses
33. Gloves - Sterile (size: 6, 7, 8) x2
34. Gown/Apron - disposable, non-sterile