KIBABII UNIVERSITY

PREQUALIFICATION OF HEALTH SERVICE PROVIDERS

HOSPITAL NAME: ……

CATEGORY NO: PREQ/KIBU/02/2020-2022 PREQUALIFICATION OF HEALTH SERVICE PROVIDERS - HOSPITALS.

TO:

KIBABII UNIVERSITY

TEL NO: 0734 831 729 or 0708 085 934

EMAIL: tenders@kibu.ac.ke

WEBSITE: www.kibu.ac.ke

TABLE OF CONTENTS:

SECTION 1 Invitation to Registration of Suppliers

SECTION 2 Instruction to Applicants

SECTION 3 Application Forms

Form (I) Letter of Prequalification

Form (II) Proclamation Form

Form (III) Litigation History

Form (IV) Health Facilities Forms

SECTION 4 Evaluation Criteria

SECTION I- INVITATION FOR PREQUALIFICATION

Kibabii University intends to prequalify Health Service Providers. Interested eligible providers (Hospitals and Specialists) are invited to apply for Prequalification.

Documents containing detailed instructions and requirements may be downloaded from the Kibabii University website www.kibu.ac.ke free of charge. Applicants who downloads the prequalification document **MUST** email their names, contact details and tender number to: tenders@kibu.ac.ke

Completed registration documents in a plain sealed envelope, clearly marked "**PREQUALICATION OF HEALTH SERVICE PROVIDER - HOSPITALS"** and bearing the respective **REFERENCE NUMBER & CATEGORY** but no indication of the applicants' name, should be deposited in the Tender Box at the **University Administration Entrance** or sent by post to

The Vice Chancellor
Kibabii University
P.O. Box 1699 – 50200
BUNGOMA

So as to be received on or before Thursday **17th September, 2020 at 10:00 am**

PROCUREMENT OFFICE
For: VICE CHANCELLOR, KIBABII UNIVERSITY

KIBABII UNIVERSITY IS A CORRUPT FREE ZONE;

SECTION II – INSTRUCTION TO APPLICANTS

2.1 Introduction

Kibabii University referred to as the procuring entity intends to prequalify suppliers for health service provider and medical specialist FOR THE PERIOD 2020 - 2022 FINANCIAL YEAR.

2.1.2 Prequalification is open to eligible medical specialists private hospitals and level four (4) and above government hospitals as indicated in appendix instruction to applicants. Hospitals registered with Registrar of companies under the laws of Kenya in respective services are invited to submit their Prequalification documents to the Vice Chancellor Kibabii University so that they may be Prequalified for provision of medical services.

2.1.3 Prospective providers must have carried out successful delivery of similar services to Government/Corporate/Universities/institutions of similar size. Potential provider must demonstrate the willingness and commitment to meet the Prequalification criteria.

2.2 **Submission of application**

2.2.1 Applications for Prequalification shall be submitted in a sealed envelope marked with the category name and reference number and deposited in the Tender Box located at the Administration Block, Kibabii University Main Campus OR be addressed and posted to:

The Vice Chancellor
Kibabii University
P.O. Box 1699 – 50200
BUNGOMA

So as to be received on or before **Thursday** 17th **September, 2020 at 10:00 am**

2.2.2 The tender prepared by the tenderer, as well as all correspondence and documents relating to the tender, exchanged by the tenderer and the Procuring entity, shall be written in English language. Any printed literature furnished by the tenderer may be written in another language provided they are accompanied by an accurate English translation of the relevant passages in which case, for purposes of interpretation of the tender, the English translation shall govern.

2.3 **Eligibility of applicants**

2.3.1 This invitation for Prequalification is open to all candidates who are eligible as defined in the Kenya Public Procurement Asset and Disposal Act, 2015 and it's Regulations.

2.3.2 The Kibabii University employees, committee members, board members and their relatives' (spouse and children) are not eligible to participate.

2.3.3 Any public owned sector or hospital may be eligible to qualify if in addition to meeting all the above requirements, it is also legally and financially autonomous, it operates under commercial law, and it is not a dependent agency of another public entity

2.4 Qualification Criteria

2.4.1 The attached questionnaire forms described are to be completed by prospective providers who wish to be Prequalified for submission of tender for health services.

2.4.2 The Prequalification application forms which are not dully filled and submitted in the prescribed manner will not be considered. All the documents that form part of the proposal must be written in English and indelible.

2.4.3 **The audited accounts**: The supplier's financial condition will be determined by the last two years audited financial statement submitted with the application documents as well as letters of reference from previous performances. Potential providers will be prequalified on the satisfactory information given.

Special consideration will be given to the financial resources available as working capital, taking into account the amount of uncompleted orders on contract and now in progress. Potential bidders shall provide evidence to execute the contract.

2.4.5 **Litigation history**: the applicant should provide accurate information about ligation or arbitration resulting from contracts completed or uncompleted under its execution stamped and signed by the Commissioner of Oaths..

2.4.6 Past Performance: will be given due consideration in Prequalification of suppliers.

2.4.7 Statement: Application must include a sworn statement by the provider ensuring the accuracy of the information given.

2.4.8 Withdrawal of Prequalification: Should a condition arise between the time the firm is applying to Prequalify and the bid opening date which could substantially change the performance and qualification of the bidder or the ability to perform such as but not limited to bankruptcy, change of ownership or new commitments, the Kibabii University reserves the right to reject the tender from such a bidder even though they have been initially Prequalification

2.4.9 Business premises: The firm must have a Physical/fixed Business premise and must be registered in Kenya with certificate of Registration, Incorporation/Memorandum and articles of Association. Copies of Physical Office, location must be attached.

2.4.10 The firm must show proof that it has paid all it statutory obligations and have a Valid Tax Compliance Certificate.

SECTION III: APPLICATION FORMS.

Form I - LETTER OF PREQUALIFICATION

Prequalification category Ref: No PREQ/KIBU/02/2020-2022 - PREQUALICATION OF HEALTH SERVICE PROVIDER - HOSPITALS.

To: The Vice Chancellor
Kibabii University
P.O. Box 1699 – 50200
BUNGOMA

Dear Sir:

1. Having examined the application documents including of which is hereby duly acknowledged, we the undersigned, offer to provide health services to Kibabii University staff, staff dependent and students and as may otherwise be directed.
2. We undertake if our application is acceptable to provide health service in accordance with the delivery schedule in the schedule of requirement or official order signed by authorized officer/s of the University.
3. We agree to abide by this application for the period of processing the applications and prepared and executed, this application together with written acceptance thereof shall constitute a binding agreement between us.
4. We understand
    a. That this is an application for consideration to be Prequalified as a Kibabii University provider of health services, during the period between the year **2020 -2022**
    b. That you are not bound to accept this application or any other that you may receive**.**
5. We have attached to this application copies of original documents of:
    a) Registration/ incorporation certificate
    b) PIN Certificate
    c) VAT Certificate
    d) Valid tax compliance certificate
    e) Current operating license from professional KMPDB or any other recognized medical Body
    f) Specialist practicing license

We make this application with full understanding that:

i. Bids by Prequalification applicants will be subject to verification of all information submitted.
ii. Kibabii university reserves the right to accept or reject any application, cancel the Prequalification process and reject all applications

The undersigned declare that the statements made and the information provided in the duly completed application are complete made, true and correct in every detail.

Sign and stamp …….

Witnessed by …….

Designation …….

Date ……

Form II: PROCLAMATION /SWORN STATEMENT/DECLARATION

I/We the undersigned, state that, ALL the information we have given provided in this document is correct/accurate to the best of our knowledge and that I/We give Kibabii University authority to seek any reference it may deem vital while carrying out their evaluation. I/We also hereby declare that the company is not debarred from participating in any public procurement proceeding.

Name of applicant……..Designation…….Signature……

Witnessed by……Designation…….Signature……..

Official rubber stamp

State if you have any relationship with Kibabii University employee (which relationship)

……
……

Information submitted by……

Title……

Signature ……

Stamp……

Form III **LITIGATION HISTORY FORM**

Name of the Hospital/Specialist

The Hospitals/Specialists should provide information on any history litigation or arbitration resulting from contracts executed in the last one year or currently under execution

YEAR	AWARD FOR OR AGAINST	NAME OF CLIENT ,CAUSE FOR LITIGATION AND MATTER IN DISPUTE	DISPUTED AMOUNT(CURRENT VALUE.KSHS.EQUIVALENT)

Form IV: HEALTH FACILITY FORM

KIBU ASSESSMENT CHECKLIST FOR DECLARATION OF HEALTH FACILITIES

Table of Contents

Table of Contents....2

SECTION 1: ADMINISTRATIVE INFORMATION....5

SECTION 2: HEALTH FACILITY INFRASTRUCTURE....6

SECTION 3: LEADERSHIP, PATIENT RIGHTS, CLINICAL GOVERNANCE, HUMAN RESOURCE MANAGEMENT....7

SECTION 4: INFECTION PREVENTION AND CONTROL....10

SECTION 5: CONSULTATION SERVICES....11

SECTION 6: MATERNITY UNIT....12

SECTION 7: GENERAL WARDS....14

SECTION 8: THEATRE....15

SECTION 9: PHARMACY....16

SECTION 10: LABORATORY (Applicable for general outpatient and inpatient services)....17

SECTION 11: RADIOLOGY....19

SECTION 12: OTHER SUPPORT SERVICES....21

SECTION 13: SAFETY AND RISK MANAGEMENT....22

SECTION 14: POPULATION ENGAGEMENT AND FACILITY OUTCOMES....23

SECTION: 15 EYE UNIT....24

SECTION 16: HDU/ICU....26

SECTION 17: DENTAL UNIT....27

SECTION 18: RENAL UNIT....30

SECTION 19: DRUG AND SUBSTANCE ABUSE TREATMENT AND REHABILITATION SERVICES....31

SECTION 20: ONCOLOGY UNIT....33

SECTION 21: FOR OFFICIAL USE ONLY: FINDINGS AND RECOMMENDATIONS....37

NUMBER	SERVICE PROVISION	✓ STATE WHETHER SERVICE IS OFFERED OR NOT.	VALIDATE (SIGNATURE)
1.	**OUTPATIENT**		
2.	**INPATIENT**		
3.	**MATERNITY**		
4.	**MAIN THEATRE**		
5.	**PHARMACY**		
6.	**LABORATORY**		
7.	**RADIOLOGY**		
8.	**EYE UNIT**		
9.	**ICU/HDU**		
10.	**DENTAL UNIT**		
11.	**RENAL UNIT**		
12.	**REHAB (DRUG & SUBSTANCE ABUSE)**		
13.	**ONCOLOGY**		
14.	**REHAB (PHYSIOTHERAPY & OR OCCUPATIONAL THERAPY)**		
15.	**OTHERS**		

Hospital Representative Names_____Signature_____Date_____

Section	Sections to be filled	MARKS	Scope
1	Administrative Information	N/A	All
2	Health Facility Infrastructure	11	
3	Leadership, Patient Rights , Clinical Governance , Human Resource Management	43	
4	Infection Prevention And Control	18	
13	Safety And Risk Management	5	
14	Population Engagement And Outcomes	6	
5	Consultation	26	
9	Pharmacy	9	All Except stand-alone labs
10	Laboratory	22	OPC, IPC, STAND ALONE LABS,
11	Radiology	16	OPC, IPC, DENTAL CLINICS ,STAND ALONE
6	Maternity Unit	32	IPC
7	General Wards	26	IPC
8	Theatre	20	IPC
12	Other Support Services	11	IPC
15	Eye Unit	38	OPC, IPC,STAND ALONE CLINICS
17	Dental Unit	39	OPC, IPC, STAND ALONE CLINICS
16	ICU	11	IPC ONLY
18	Renal Unit	11	OPC, IPC , STAND ALONE RENAL UNIT
19	Drug And Substance Abuse Treatment And Rehabilitation Service	19	REHAB FACILITIES
20	Oncology Unit	27	OPC, IPC

Hospital Representative Names_____Signature_____Date_____

SECTION 1: ADMINISTRATIVE INFORMATION			
Facility Registration and Location			
Registration/Gazette name:			
Master facility number:		Registration number (for private facilities):	
Physical location:		Contact details:	
County:		Contact Person:	
Address:		Designation of contact person:	
Nearest Town/Market:			
Building plot no:		Phone number:	
Nearest NHIF Office:		Email:	
Facility Details			
Facility ownership	☐Government ☐Private ☐Faith Based ☐Community		
Facility type	☐ Both In and Out Patient ☐ Outpatient Only ☐ Radiology Centre (Stand – alone) ☐Dental clinic (Stand-alone) ☐ Ophthalmic services (Stand - alone) ☐ Dialysis Centre ☐ Oncology Centre ☐ Rehabilitation Centre for drug & Substance Abuse ☐Other facility, Specify [_____]		

Hospital Representative Names_____Signature_____Date_____

A. Building				Comments
	Signage	Assessment		
i	There is adequate, legible and accurate signage to the facility From major access points outside the premises of the health establishment.	Y ☐	N ☐	
ii	There is clear signage and direction to the services or areas Within the health establishment.	Y ☐	N ☐	
iii	Does the facility have an accessibility ramp for Disabled/wheelchair patients?	Y ☐	N ☐	
B. Utilities				
	Water	Assessment		**Comments**
iv	Is safe, clean water available from a tap or container?	Y ☐	N ☐	
v	Is there sufficient storage/reservoir for the water?	Y ☐	N ☐	
	Electricity			
vi	Is there a stable source of power?	Y ☐	N ☐	
	Toilet facilities			
vii	Are clean toilets available for both male and female clients?	Y ☐	N ☐	
viii	Is there a cleaning roster displayed?	Y ☐	N ☐	
C. Security				
	Fire control mechanism	Assessment		**Comments**
ix	Does the facility have a fire control mechanism such as a fire extinguisher, sand buckets?	Y ☐	N ☐	
x	Is the equipment available in the reception area as well as Specific departments?	Y ☐	N ☐	
xi	Is there a security mechanism in place (security guard, alarm System, fence)?	Y ☐	N ☐	
	TOTAL 11 (In this Section Yes has a value equivalent of 1)			

Hospital Representative Names_____Signature_____Date_____

A. Leadership				Comments
	I. Strategic Plan	Assessment		
i	The facility has a strategic plan with a clear vision, mission, values And objectives and has been shared with staff.	Y ☐	N ☐	
ii	Roles and responsibilities of every member in the top decision Making organ are clearly stipulated and monitored to ensure compliance with ethical business practice.	Y ☐	N ☐	
iii	There is evidence of supportive attitude towards systematic and Continuous quality improvement by the top management.	Y ☐	N ☐	
iv	Is an organizational chart available and approved by management?	Y ☐	N ☐	
B. Patient Rights		Assessment		
v	There is an openly displayed patient charter in line with the Ministry of Health guidelines which includes but not limited to right to information, privacy, dignity, choice and the price list.	Y ☐	N ☐	
vi	Staffs treat patients with care and respect, with consideration for Patient privacy and choice.	Y ☐	N ☐	
vii	Patient satisfaction surveys and patient complaints are used to Improve service quality.	Y ☐	N ☐	
viii	Patients who need to be referred or transferred receive the Care and support they need to ensure continuum of care.	Y ☐	N ☐	
ix	Patients who wish to complain about poor services are helped to Do so and their concerns are properly addressed.	Y ☐	N ☐	
C. Clinical Governance		Assessment		
x	There is a governance system that sets out the policy, procedures or protocols for: Establishing and maintaining a clinical governance framework; Sharing the framework with all staff; Collecting and reviewing performance data; Taking corrective action.	Y ☐	N ☐	
xi	Services provided adhere to Ministry of Health guidelines and/or Licensing specifications and the clinical workforce is guided by current best practice.	Y ☐	N ☐	
xii	Clinical guidelines are in place and are known and utilized by all Users.	Y ☐	N ☐	
xiii	Referral guidelines are in place and are known and utilized by all users.	Y ☐	N ☐	

Hospital Representative Names_____Signature_____Date_____

D. Human Resource Management							Assessment		Comments
xiv	Availability of staff establishment as per hospital level of care.						Y ☐	N ☐	
xv	Complete inventory of staff, including training, registration with Relevant bodies, designation and mode of engagement (i.e. whether permanent or part time).						Y ☐	N ☐	
xvi	Availability of job descriptions for all staff, known and shared with Respective staff.						Y ☐	N ☐	
xvii	Relevant training and development opportunities are provided to Enhance staff competence.						Y ☐	N ☐	
xviii	Availability of a staff performance management system, including Appraisal, discipline and rewards.						Y ☐	N ☐	
E. Quality Management							Assessment		Comments
xix	The facility has an active quality improvement team.						Y ☐	N ☐	
xx	Is there evidence of the last QIT meeting held, within the last Three (3) months?						Y ☐	N ☐	
xxi	There is evidence of implementation of Quality Improvement Plans.						Y ☐	N ☐	
F. Monitoring Performance Indicators							Assessment		Comments
xxii	Which of these performance indicators are collected and Monitored?						Y ☐	N ☐	
xxiii	Infant mortality	Y ☐	N ☐	Maternal mortality	Y ☐	N ☐	Y ☐	N ☐	
xxiv	Immunization	Y ☐	N ☐	Notifiable diseases	Y ☐	N ☐	Y ☐	N ☐	
xxv	Admissions	Y ☐	N ☐	Outpatient visits	Y ☐	N ☐	Y ☐	N ☐	
xxvi	Are performance indicators shared with staff and published regularly						Y ☐	N ☐	
G. Client Feedback Mechanism							Assessment		Comments
xxvii	Is there a functional client feedback mechanism (e.g. suggestion Box or hotline number)?						Y ☐	N ☐	
xxviii	There is evidence of utilization of the client feedback.						Y ☐	N ☐	

Hospital Representative Names_____Signature_____Date_____

H. Medical Records And Information Systems		Assessment		Comments
xxix	Are medical records kept for each patient?	Y ☐	N ☐	
xxx	Do the records include names and unique patient numbers?	Y ☐	N ☐	
xxxi	Are medical records legible and signed?	Y ☐	N ☐	
	Approved register for all patients			
xxxii	Are inpatient registers kept and up to date (if inpatient services)?	Y ☐	N ☐	
xxxiii	Are outpatient registers kept up to date?	Y ☐	N ☐	
xxxiv	Is there a trained HMIS Officer who also has a letter of authority For practice from the Association of Medical Records Officers?	Y ☐	N ☐	
	System for storing medical records			
xxxv	Is there a system in place for storing medical records?	Y ☐	N ☐	
xxxvi	Is there a filing and numbering system for easy retrieval?	Y ☐	N ☐	
	Data security			
xxxvii	Does a system exist for keeping facility data, which is lockable and Or password protected?	Y ☐	N ☐	
	Contribution to external databases and reports			
xxxviii	Does the facility contribute to the National HMIS* database	Y ☐	N ☐	
I.	**Equipment Management**	Assessment		
	Preventative maintenance plan for equipment			
xxxix	Is there a service contract for maintenance?	Y ☐	N ☐	
xl	Is there a written schedule (including next service date) for Maintaining equipment?	Y ☐	N ☐	
	Calibration and Validation			
xli	Is there a written calibration schedule available at the area where Equipment is used?	Y ☐	N ☐	
xlii	Is there a document showing regular calibration?	Y ☐	N ☐	
xliii	Are contracts available at the facility administration?	Y ☐	N ☐	
	TOTAL 92 (In this Section Yes has a value equivalent of 2)			

*HMIS-Health Management Information System

Hospital Representative Names_____Signature_____Date_____

SECTION 4: INFECTION PREVENTION AND CONTROL				
A. General		Assessment		**Comments**
	1. Hygiene protocol			
I	Does the facility have a hygiene protocol?	Y ☐	N ☐	
ii	Does the hygiene protocol have a dedicated staff roster?	Y ☐	N ☐	
	2. Solid waste management			
iii	Is there a standard operating procedure for waste management?	Y ☐	N ☐	
iv	Is there an incinerator or contracted waste management company?	Y ☐	N ☐	
v	Does the facility have a waste holding area?	Y ☐	N ☐	
	3. General facility cleanliness			
	Facility cleanliness entails the general appearance and odor across various Departments, to understand whether the facility is cleaned regularly. Observe how well this facility satisfies the criterion below.			
vi	Is the paint work acceptable?	Y ☐	N ☐	
vii	Is the floor smooth?	Y ☐	N ☐	
viii	Is the ceiling free of cobwebs and dust?	Y ☐	N ☐	
	4. General compound cleanliness			
ix	Is the grass well maintained?	Y ☐	N ☐	
x	Are the bushes neatly kept?	Y ☐	N ☐	
xi	Is the site free of odor?	Y ☐	N ☐	
	5. Patient Safety			
xii	There is a policy to identify and manage patients correctly to Eliminate errors.	Y ☐	N ☐	
xiii	Are adverse events or patient safety incidents promptly identified And managed to minimize patient harm and suffering?	Y ☐	N ☐	
B. Sterilization Services		Assessment		**Comments**
xv	Is there a separate area for cleaning with decontamination and Sterilization processes?	Y ☐	N ☐	
xvi	Is there functional equipment for sterilization?	Y ☐	N ☐	
xvii	Are standard operating procedures available for sterilization?	Y ☐	N ☐	
xviii	Are sterile supplies well stored, labeled and stored in a designated Area?	Y ☐	N ☐	
xix	Is the facility fully compliant in the practice of infection control?	Y ☐	N ☐	
	TOTAL 38 (In this Section Yes has a value equivalent of 2)			

Hospital Representative Names_____Signature_____Date_____

A. General		Assessment		Comments
	Triage			
i	Does the facility have a triage area with a qualified nurse(s)?	Y ☐	N ☐	
ii	Is it located at the first point of contact with patients?	Y ☐	N ☐	
	Examination room			
iii	There is a room(s) set aside where patients/clients can consult with a clinician and be examined in confidence.	Y ☐	N ☐	
iv	Does the examination room have a coach and a mackintosh?	Y ☐	N ☐	
v	Does the room have a consultation table with at least two chairs?	Y ☐	N ☐	
	Examination equipment			
vi	Is a thermometer available?	Y ☐	N ☐	
vii	Is a stethoscope available?	Y ☐	N ☐	
viii	Is a tongue depressor available?	Y ☐	N ☐	
ix	Is a weighing scale available/accessible?	Y ☐	N ☐	
x	Is a blood pressure (BP) machine available/accessible?	Y ☐	N ☐	
xi	Is a torch available?	Y ☐	N ☐	
xii	Is a privacy screen available?	Y ☐	N ☐	
xiii	Is a diagnostic set available?	Y ☐	N ☐	
xiv	Is a lamp available?	Y ☐	N ☐	
	Emergency tray and equipment			
xv	Does the facility have an emergency tray available at designated Sites?	Y ☐	N ☐	
xvi	Is there a checklist for regular review and updates to the Emergency tray?	Y ☐	N ☐	
xvii	Confirm that the emergency tray has the following essential drugs: Glucose Adrenaline Sodium bicarbonate Diazepam Phenobarbitone	 Y ☐ Y ☐ Y ☐ Y ☐ Y ☐	 N ☐ N ☐ N ☐ N ☐ N ☐	
xviii	Confirm that the emergency equipment is available: Ambu bag and mask available in pediatric and adult sizes. Adjustable bed. Functional suction machine. Oxygen cylinder and flowmeter, or piped oxygen. Endotracheal tubes.	Y ☐ Y ☐ Y ☐ Y ☐ Y ☐	N ☐ N ☐ N ☐ N ☐ N ☐	
	TOTAL 26 (In this Section Yes has a value equivalent of 1)			

Hospital Representative Names_____Signature_____Date_____

A. General		Assessment		Comments
	Labour ward Policies			
i	A policy that governs ante natal, intrapartal, post-natal and Neonatal care exists.	Y ☐	N ☐	
ii	Policy in place for pain management during and after delivery that Is known to the staff and implemented.	Y ☐	N ☐	
iii	There is a maternity infection prevention programme in place.	Y ☐	N ☐	
iv	A system is in place to monitor Labour progress.	Y ☐	N ☐	
v	A policy on infection prevention and control.	Y ☐	N ☐	
	Oxygen source			
vi	Does the labour ward have oxygen cylinder or piped oxygen Connection?	Y ☐	N ☐	
	Procedures for obstetrics emergency			
vii	Are there procedures available for handling obstructed labour, Foetal distress, HELLP, Eclampsia and APH/PPH/IPH?	Y ☐	N ☐	
viii	Is a functional resuscitative available with oxygen, suction machine And Ambu bags?	Y ☐	N ☐	
	Procedure for monitoring labour			
ix	Are partographs available?	Y ☐	N ☐	
	Confirm partographs have the following information:			
xi	Is contraction properly charted?	Y ☐	N ☐	
	Is cervical dilation recorded?	Y ☐	N ☐	
	Is color coding done?	Y ☐	N ☐	
	Is TPR/BP recorded?	Y ☐	N ☐	
	Is urine output/input charted?	Y ☐	N ☐	
	Are drugs coded?	Y ☐	N ☐	
	New born unit			
xvi	Access to a functional incubator available.	Y ☐	N ☐	
xvii	Is there a sitting area for nursing mothers?	Y ☐	N ☐	
	Sluice Room			
xviii	Is a sluice room/area available and properly located?	Y ☐	N ☐	
xix	Is there a sluicing sink with running water?	Y ☐	N ☐	

Hospital Representative Names_____Signature_____Date_____

B. **Equipment**		**Assessment**		**Comments**
xx	Standard delivery bed.	Y ☐	N ☐	
xxi	Fetoscopes.	Y ☐	N ☐	
xxii	Weighing scale.	Y ☐	N ☐	
xxiii	BP machine.	Y ☐	N ☐	
xxiv	Cord ligatures.	Y ☐	N ☐	
xxv	Suction machine.	Y ☐	N ☐	
xxvi	Adequate source of lighting.	Y ☐	N ☐	
xxvii	Source of oxygen.	Y ☐	N ☐	
xxviii	Baby Resuscitative.	Y ☐	N ☐	
xxix	Adequate sterile delivery sets.	Y ☐	N ☐	
C. Delivery through Caesarean Section		**Assessment**		**Comments**
xxx	Does the facility have access to a maternity /general theatre?	Y ☐	N ☐	
xxxi	Does the facility have access to ambulance?	Y ☐	N ☐	
xxxii	Does the facility have access to the blood bank?	Y ☐	N ☐	
	TOTAL 96 (In this Section Yes has a value equivalent of 3)			

*APH-Antepartum Haemorrhage
*IPH-Intrapartum Haemorrhage
*PPH-Postpartum Haemorrhage
*HELLP-Haemolysis, Elevated Liver enzymes, Low Platelets (syndrome associated with Pre-eclampsia)

Hospital Representative Names_____Signature_____Date_____

A. General		Assessment		Comments
	1. Patient Oversight			
i	Ward beds are segregated by gender and age.	Y ☐	N ☐	
ii	Are admissions procedures standardized with patient categorizations?	Y ☐	N ☐	
iii	Are patients in hospital uniform?	Y ☐	N ☐	
iv	Are there regular ward rounds?	Y ☐	N ☐	
v	Are there handover and discharge reports on a standard form?	Y ☐	N ☐	
	2. Patient Records			
vi	Are patient records kept with unique reference numbers?	Y ☐	N ☐	
	3. Monitoring Equipment			
vii	Does each ward have a BP machine?	Y ☐	N ☐	
viii	Does each ward have a thermometer?	Y ☐	N ☐	
ix	Does each ward have a pulse oxymeter?	Y ☐	N ☐	
x	Does each ward have a suction machine?	Y ☐	N ☐	
xi	Bed spacing is at least 3 feet apart.	Y ☐	N ☐	
xii	Beds are metallic and easy to disinfect.	Y ☐	N ☐	
xiii	Does each ward have an emergency room?	Y ☐	N ☐	
xiv	Is there an ablution block available, segregated by gender?	Y ☐	N ☐	
B. Infection prevention and control				
	Hygiene Protocol			
xv	Is there a hygiene protocol with a dedicated staff roster available?	Y ☐	N ☐	
	Hand Washing			
xvi	Is a sink present with running water from a tap or modified storage Container?	Y ☐	N ☐	
xvii	Is soap or hand sterilizer available at the hand washing area?	Y ☐	N ☐	
	Solid Waste Management			
xviii	Are there (at least two) color-coded bins (black and yellow) with Matching color lining bags?	Y ☐	N ☐	
xix	Or are there color coded lining bags in the bins?	Y ☐	N ☐	
xx	Are there standard operating procedures for waste management?	Y ☐	N ☐	
	Use of Disinfectants			
xxi	Is there evidence of disinfectant use?	Y ☐	N ☐	
xxii	Are you able to observe disinfectant containers used for cleaning?	Y ☐	N ☐	
	Protective Equipment			
xxiii	Are gloves available?	Y ☐	N ☐	
xxiv	Are gowns or dust coats available?	Y ☐	N ☐	
xxv	Are face masks available?	Y ☐	N ☐	
xxvii	Are safety boots available?	Y ☐	N ☐	
	TOTAL 78 (In this section Yes has a value equivalent of 3)			

Hospital Representative Names_____Signature_____Date_____

A. General		Assessment		Comments
	1. Policies			
i	There is a policy on obtaining an informed consent from patients And/or their relatives who are undergoing invasive procedures.	Y ☐	N ☐	
ii	Theatre services are available 24/7.	Y ☐	N ☐	
iii	Infection prevention policies and protocols in place.	Y ☐	N ☐	
	2. Receiving and Recovery Areas			
iv	There is a designated area for receiving patients and post-Anesthesia recovery.	Y ☐	N ☐	
v	Availability of gender-specific changing rooms and adequate Linen.	Y ☐	N ☐	
vi	There is a specific area set aside where staffs scrub for Operations.	Y ☐	N ☐	
vii	Does the receiving area have adequate lighting?	Y ☐	N ☐	
	3. Operating Area			
viii	There is adequate space in the operating area allowing for free Movement of theatre staff.	Y ☐	N ☐	
ix	There is adequate lighting from both overhead and flexible light Sources in operating area.	Y ☐	N ☐	
x	There are adequate sterile gloves in different sizes in the Operating room.	Y ☐	N ☐	
xi	There is a standard adjustable operating table.	Y ☐	N ☐	
xii	There are at least two functional anaesthetic machines in the Operating room.	Y ☐	N ☐	
xiii	There are adequate ambu-bags, both adult and paediatric in the Operating Room.	Y ☐	N ☐	
xiv	Patient monitor(s) is available and in good working condition in the Operating Room.	Y ☐	N ☐	
xv	Theatre utilities, including functional laryngoscopes, endotracheal tubes, suction machines and suction tubes are available in different sizes to cater for both adult and paediatric clients.	Y ☐	N ☐	
xvi	There is a reliable source of back-up oxygen, separate from anaesthetic machines.	Y ☐	N ☐	
xvii	There is a designated area for sterilizing equipment.	Y ☐	N ☐	
	4. Sluice Room			
xviii	Is a sluice room/area available and properly located?	Y ☐	N ☐	
xix	Is there a sluicing sink with running water?	Y ☐	N ☐	
	5. Staff Requirements			
xx	Are there at least three theatre staff (scrub, runner and anaesthetic nurse)?	Y ☐	N ☐	
	TOTAL 100 (In this Section Yes has a value equivalent of 5)			

Hospital Representative Names_____Signature_____Date_____

A. General Policies and guidelines		Assessment		Comments
i	Pharmaceutical unit is licensed by Pharmacy & Poisons Board.	Y ☐	N ☐	
ii	Pharmacy is supervised by a trained and registered Pharmacist or other qualified personnel appropriate for the level of care.	Y ☐	N ☐	
iii	The facility has procedures for ordering, acquiring, storing, dispensing and disposing pharmaceutical products.	Y ☐	N ☐	
iv	Safety procedures, protocols in relation to medication available.	Y ☐	N ☐	
B. Storage and display of commodities		**Assessment**		**Comments**
v	Does the pharmacy have secure, lockable cupboards for restricted drugs only accessible by authorized persons (e.g. narcotics and psychotropics).	Y ☐	N ☐	
C. Record keeping and documentation		**Assessment**		**Comments**
vi	Does the pharmacy have a well-explained system for recording prescriptions?	Y ☐	N ☐	
vii	Does the pharmacy have standard operating procedures for disposal of expired drugs?	Y ☐	N ☐	
vii	Is there a daily updated inventory system showing which commodities are available?	Y ☐	N ☐	
ix	Is there documentation showing where medicines are procured?	Y ☐	N ☐	
	TOTAL 36 (In this Section Yes has a value equivalent of 4)			

Hospital Representative Names_____Signature_____Date_____

A. Policies, guidelines and SOPs		Assessment		Comments
	Reporting procedures			
i	The Unit is licensed by the Kenya Medical Laboratory Board.	Y ☐	N ☐	
ii	The facility has existing standard operating procedures for collecting, labelling, preparing, storing, interpreting and disposal of specimens; which are known by all staff working in the laboratory.	Y ☐	N ☐	
iii	Availability of an updated inventory of equipment.	Y ☐	N ☐	
iv	Register of all tests done and turnaround time for each test is recorded.	Y ☐	N ☐	
v	The laboratory has SOPs and guidelines for reporting laboratory procedures according to license class.	Y ☐	N ☐	
vi	The Laboratory has infection prevention protocols in place.	Y ☐	N ☐	
B. Equipment Management Program				
	Calibration and validation of equipment			
vii	Does the lab have a system for regular calibration/validation of equipment available?	Y ☐	N ☐	
viii	Is the system for calibration/validation of equipment placed close to respective equipment?	Y ☐	N ☐	
	Equipment maintenance documentation			
ix	Does the laboratory have a systematic, well-documented equipment maintenance schedule?	Y ☐	N ☐	
x	Register of maintenance and calibration of equipment available.	Y ☐	N ☐	
xi	Are service contracts available for all lab equipment?	Y ☐	N ☐	
xii	Does lab have a system for equipment procurement that is known by staff (one other staff to explain)?	Y ☐	N ☐	
xiii	Does the laboratory have a list of all equipment in use?	Y ☐	N ☐	
xiv	Does the laboratory have a functional inventory management system?	Y ☐	N ☐	

Hospital Representative Names_____Signature_____Date_____

C. Quality Control of Tests		Assessment		Comments
	Quality control practices			
xv	Are equipment registered, validated and calibrated?	Y ☐	N ☐	
xvi	Is there documentation of quality control of tests?	Y ☐	N ☐	
xvii	Is there a documented system for regular review and improvement of laboratory tests?	Y ☐	N ☐	
xviii	Is there documentation of sample archiving, retrieval and disposal?	Y ☐	N ☐	
xix	Is Internal Quality Control (IQC) done regularly?	Y ☐	N ☐	
xx	Is the laboratory enrolled in any External Quality Assurance System?	Y ☐	N ☐	
	Procurement and storage of reagents			
xxi	Does the laboratory have a functional temperature recording system in place?	Y ☐	N ☐	
xxii	Are standards for procurement and safe storage of reagents in place, including an inventory of all reagents?	Y ☐	N ☐	
	TOTAL 66 (In this Section Yes has a value equivalent of 4)			

Attach license from the Kenya Medical Laboratory Technicians & Technologist Board

Hospital Representative Names_____Signature_____Date_____

A. Radiation Protection		Assessment		Comments
	Personal radiation dose monitoring			
i	Are personal radiation dose monitoring badges worn daily and evaluated monthly by the Radiation Protection Board.	Y ☐	N ☐	
	Radiation safety service provider			
ii	Facility is licensed by Radiology Protection Board.	Y ☐	N ☐	
iii	The facility has records confirming that there is a radiation safety service provider for monitoring exposure to radiation and safety of workers and patients.	Y ☐	N ☐	
	Adequate number of lead aprons			
iv	Are there an adequate number of lead aprons, i.e. a minimum of three: one each for the patient, patient-guardian and radiographer?	Y ☐	N ☐	
	Radiological examination in pregnancy			
v	Is a code of practice for pregnant women available and producible?	Y ☐	N ☐	
	Quality assurance of image processing			
vi	Is there evidence of quality assurance of the image processing system (it may be digital, automatic or manual)?	Y ☐	N ☐	
B. Policies, SOPs and Registers		**Assessment**		**Comments**
	Policies, SOPs and Code of Practice			
vii	Standard operating procedures are available for different radiological and imaging services.	Y ☐	N ☐	
viii	There is evidence that they are reviewed regularly based on evidence-based current radiological practice.	Y ☐	N ☐	
ix	There is a code of practice displayed next to the respective radiological devices.	Y ☐	N ☐	
x	There are records for all radiological examinations carried out, indicating the requesting clinician, the radiologist/radiographer who performed the exam and the findings of the exam.	Y ☐	N ☐	
xi	Infection prevention and control policies documented and in place.	Y ☐	N ☐	

Hospital Representative Names_____Signature_____Date_____

C. Radioactive Waste Management		Assessment		Comments
	Personal safety measures			
xii	Does the facility produce radioactive waste?	Y ☐	N ☐	
xii	Are patient and staff safety measures implemented alongside routine waste management tasks?	Y ☐	N ☐	
	Radioactive waste management programs in place			
xiv	Is there designated staff in charge of radioactive waste management?	Y ☐	N ☐	
xv	Are there records showing that radioactive waste management systems are in place?	Y ☐	N ☐	
	Designated staff for radioactive waste management programs			
xvi	Does the facility have designated personnel to oversee radioactive waste management programs?	Y ☐	N ☐	
	TOTAL 64 (In this Section Yes has a value equivalent of 4)			

Hospital Representative Names_____Signature_____Date_____

SECTION 12: OTHER SUPPORT SERVICES				
A. Food & House Keeping		**Assessment**		**Comments**
	Food			
i	Nutritionist available in the facility.	Y ☐	N ☐	
ii	There is a guideline on food appropriate for the patient and consistent with his/her clinical care that is available which include; Orders for nil by mouth, regular diet, special diet and parenteral/nasogastric tube nutrition	Y ☐	N ☐	
iii	Does the person handling food have appropriate uniform and are medically examined every 6 months	Y ☐	N ☐	
iv	There is a policy in place that ensures the food preparation, handling and storage are safe	Y ☐	N ☐	
	House Keeping			
v	The housekeeping service is managed to ensure the provision of a safe and effective service	Y ☐	N ☐	
	Linen service management			
vi	There is a policy in place to ensure there is adequate and appropriate linen to meet patients need.	Y ☐	N ☐	
vii	The linen service is managed to ensure the provision of a safe and effective service.	Y ☐	N ☐	
B. Mortuary		**Assessment**		**Comments**
viii	There is a policy to identify, preserve, store and safely discharge bodies.	Y ☐	N ☐	
ix	Equipment for storage and transportation of bodies meet environmental hygiene standards	Y ☐	N ☐	
x	Practices within the morgue should subscribe within the laid down procedures.	Y ☐	N ☐	
xi	Mortuary staff wear protective gear to prevent accident, injury or infection	Y ☐	N ☐	
	TOTAL 33 (In this Section Yes has a value equivalent of 3)			

Hospital Representative Names_____Signature_____Date_____

A. Policies		Assessment		Comments
i	Written policies and procedures on all aspects of health and safety guide the personnel in maintaining a safe work environment.	Y ☐	N ☐	
ii	Post exposure prophylaxis (PEP) is available to the personnel in accordance to the organizational policy.	Y ☐	N ☐	
iii	There is a policy on reporting reactions to drugs or severe side effects and how to care for a patient in such events	Y ☐	N ☐	
iv	There is a programme in identifying preparing mitigation and managing disaster incidents including but not specific to fire, mass accidents flood, and other emergencies.	Y ☐	N ☐	
v	There is a policy to identify and manage patients correctly to eliminate errors.	Y ☐	N ☐	
	TOTAL 15 (In this Section Yes has a value equivalent of 5)			

Hospital Representative Names_____Signature_____Date_____

A. Patient Clients' Outcomes		Assessment		Comments
i	Facility has mechanism to trigger stakeholders feedback and involvement on health services planning, provision, outcomes, impact and satisfaction	Y ☐	N ☐	
ii	Patients'/clients' views and level of satisfaction are assessed at planned intervals e.g. through exit interviews.	Y ☐	N ☐	
iii	Results shall be documented and acted upon, e.g. analyzed and considered in improvement plans.	Y ☐	N ☐	
iv	Mechanisms for patient/client feedback is in place	Y ☐	N ☐	
B. Facility Outcomes		**Assessment**		**Comments**
v	The performance of health facilities is assessed on a regular basis.	Y ☐	N ☐	
vi	The indicators listed below are calculated on a monthly basis and monitored over time. Expenditure/revenue ratio Total financial resources in relation to number of beds. Overall death rate (deaths / admissions) Number of maternal deaths in facility Number of deliveries Neonatal deaths	Y ☐	N ☐	
	TOTAL 12 (In this Section Yes has a value equivalent of 2)			

Hospital Representative Names_____Signature_____Date_____

A. Policies		Assessment		Comments
i	The facility has in place a policy to identify, diagnose, interpreted and manage eye related problems	Y ☐	N ☐	
ii	Procurement, storage, requisition, dispensing before expiry, labeling, installation, maintenance, administration & disposal of Ophthalmology medication, materials, equipment & instruments in line with International standards and manufacturers Guidelines.	Y ☐	N ☐	
B. Equipment				
	Basic Diagnostic equipment			
iii	Eye Chart	Y ☐	N ☐	
iv	Slit Lamp	Y ☐	N ☐	
v	Direct Ophthalmoscope	Y ☐	N ☐	
vi	Tonometer	Y ☐	N ☐	
vii	Refraction Set	Y ☐	N ☐	
viii	Pen Torch	Y ☐	N ☐	
ix	Retinoscope	Y ☐	N ☐	
x	Indirect Ophthalmoscope	Y ☐	N ☐	
xi	Applanation	Y ☐	N ☐	
xii	Tonopen	Y ☐	N ☐	
xiii	Lenses(20D,78D,90D)	Y ☐	N ☐	
xiv	3 Mirror Lens	Y ☐	N ☐	
xv	Visual Perimetery apparatus	Y ☐	N ☐	
xvi	Ophthalmic Operating Microscope	Y ☐	N ☐	

Hospital Representative Names_____Signature_____Date_____

C. Basic Surgical Equipment		Assessment		Comments
xvii	Keratometer	Y ☐	N ☐	
xviii	A-Scan	Y ☐	N ☐	
xix	Operating Instrument Sets,	Y ☐	N ☐	
xx	Basic Anterior Segment Set (Cataract And Glaucoma), Lid surgery, Squint, Orbital surgery , Vitreoretinal surgery	Y ☐	N ☐	
xxi	Operating room space,	Y ☐	N ☐	
xxii	Ophthalmic Operating table and chair, trolley, drip stand,	Y ☐	N ☐	
xxiii	sterilization equipment	Y ☐	N ☐	
xxiv	Anterior Vitrector	Y ☐	N ☐	
xxv	Paediatric(Vitrector Machines , Keratomiter,)	Y ☐	N ☐	
xxvi	Corneal Grafting Instruments	Y ☐	N ☐	
xxvii	Glaucoma(Glaucoma Laser Lenses, Puchymeter)	Y ☐	N ☐	
xxviii	Vitrio Retinal (Endo Laser, Posterior Vitrectomy Machine,	Y ☐	N ☐	
xxix	Orbital and Oculloplastic surgery equipment)	Y ☐	N ☐	
xxx	Refractive Surgery equipment	Y ☐	N ☐	
xxxi	Corneal Topography	Y ☐	N ☐	
D. Consumables		**Assessment**		**Comments**
xxxii	Local anesthetic solution and needles.	Y ☐	N ☐	
xxxiii	Sterile gauze.	Y ☐	N ☐	
xxxiv	Disposable gloves.	Y ☐	N ☐	
xxxv	Disposable face masks.	Y ☐	N ☐	
xxxvi	Cotton rolls.	Y ☐	N ☐	
xxxvii	Medical gasses and compressors are Provided for in a safe manner.	Y ☐	N ☐	
xxxviii	Policies, procedures and guidelines in place and in use as regards	Y ☐	N ☐	
	TOTAL 76 (In this Section Yes has a value equivalent of 2)			

Hospital Representative Names_____Signature_____Date_____

A. Infrastructure		Assessment		Comments
i	There is a room available set aside to offer critical care.	Y ☐	N ☐	
ii	There is availability of standard ICU bed	Y ☐	N ☐	
iii	There is quick access to theatre and laboratory	Y ☐	N ☐	
B. Human Resource		**Assessment**		**Comments**
iv	Availability of staff trained in critical care including an Anesthetist.	Y ☐	N ☐	
C. Equipment		**Assessment**		**Comments**
v	There is a policy in place for acquisition, usage, calibration, Maintenance, storage and disposal of equipment in the facility.	Y ☐	N ☐	
vi	Defibrillator	Y ☐	N ☐	
vii	Ventilator	Y ☐	N ☐	
viii	Blood Gas Analyzer.	Y ☐	N ☐	
ix	Oxygen supply	Y ☐	N ☐	
D. Policies & Programs		**Assessment**		**Comments**
x	Standard operating procedure is in place for managing different Emergencies.	Y ☐	N ☐	
xi	Infection prevention policies in place	Y ☐	N ☐	
	TOTAL 110 (In this Section Yes has a value equivalent of 10)			

Hospital Representative Names_____Signature_____Date_____

A. Infrastructure		Assessment		Comments
i	An area or a room has been set aside for dental services.	Y ☐	N ☐	
ii	There are guidelines available on diagnosis, interpretation of Various dental conditions.	Y ☐	N ☐	
B. Equipment and Tools for Dental Healthcare Services		**Assessment**		**Comments**
iii	There is a policy in place for acquisition, usage, calibration, Maintenance, storage and disposal of equipment in the facility.	Y ☐	N ☐	
iv	Available or access to an OPG machine	Y ☐	N ☐	
v	Dental Chair and unit in functional state.	Y ☐	N ☐	
vi	Operators chair and assistants' chair.	Y ☐	N ☐	
vii	Compressor.	Y ☐	N ☐	
viii	Suction machine.	Y ☐	N ☐	
ix	Autoclave.	Y ☐	N ☐	
x	Amalgamator.	Y ☐	N ☐	
xi	Light cure machine.	Y ☐	N ☐	
xii	Intra-oral x-ray machine.	Y ☐	N ☐	
xiii	Ultrasonic scaler.	Y ☐	N ☐	
xiv	High speed and slow speed hand pieces.	Y ☐	N ☐	
xv	Examination light.	Y ☐	N ☐	
xvi	Mouthwash.	Y ☐	N ☐	
xvii	Lockable Instrument cabinets.	Y ☐	N ☐	
xviii	Disposable bins with foot control (Plastic or Metallic).	Y ☐	N ☐	
xix	Amalgam filter.	Y ☐	N ☐	
xx	Working Refrigerator.	Y ☐	N ☐	
xxi	Emergency tray i.e. (Disposable syringes, adrenaline, Hydrocortisone, IV canulas etc).	Y ☐	N ☐	
xxii	Full set of extraction forceps and elevators.	Y ☐	N ☐	
xxiii	Dental syringes.	Y ☐	N ☐	

Hospital Representative Names_____Signature_____Date_____

Equipment And Tools For Dental Healthcare Services		Self Assessment		Comments
xxiv	Amalgam restoration tray i.e. (Amalgam carrier, Amalgam Condenser, Curver, Burnisher, Matrix holder and bands, Wedges, Calcium Hydroxide applicator, Carie excavator & Rotary burs). **Tick Yes if all tools are available in the tray and No if any is missing*	Y ☐	N ☐	
xxv	Composite restoration tray i.e. (Caries, excavator, Cement applicator, Enamel/Dentine Bonding agent, Acid etch set, Composite resin, Mylar strips, Composite polishing strips, Plastic applicators & Rotary burs). **Tick Yes if all tools are available in the tray and No if any is missing*	Y ☐	N ☐	
xxvi	Endodontic tray- either rotary or hand instruments i.e. (Reamers and Files, Barbed Broaches, Gutter percha condenser, Gutta percha, Paper points ,Root canal Disinfectant, Root canal Obturation Cement). **Tick Yes if all tools are available in the tray and No if any is missing*	Y ☐	N ☐	
xxvii	Diagnostic tray i.e. (Mirror, Probe, Tweezers, Periodontal probe, Cotton rolls & Vitality test kit). **Tick Yes if all tools are available in the tray and No if any is missing*	Y ☐	N ☐	
xxviii	Assorted impression trays i.e. (Upper edentulous, Lower edentulous, Lower dentate (No. 1-3), Upper dentate (No. 1-3), Paedo trays (upper and lower) & Impression material). **Tick Yes if all tools are available in the tray and No if any is missing*	Y ☐	N ☐	
xxix	Surgical tray includes all the following: Periosteal elevator, Blade holder and blades, Tissue forceps Needle holder, Sutures, Surgical scissors, High speed evacuation tips, Lower molar forceps, Upper molar forceps (left and right),Lower premolar forceps, Lower anterior forceps, Lower root forceps, Upper anterior forceps, Upper root forceps, Criers elevator (left and right), Straight elevators (No. 1,2 and 3),Root tip elevator (left and right). **Tick Yes if all tools are available in the tray and No if any is missing*	Y ☐	N ☐	

Hospital Representative Names_____Signature_____Date_____

C. Policies and Guidelines:		Assessment		Comments
xxx	Policies, procedures and guidelines in place and in use as regards procurement, storage, requisition, dispensing before expiry, labeling, installation, maintenance, administration & disposal of dental medication, materials, equipment & instruments in line with International standards and manufacturers guidelines.	Y ☐	N ☐	
xxxi	There are policies and procedures in place to govern the Management of dental materials.	Y ☐	N ☐	
xxxii	Infection prevention and control policies in place and used.	Y ☐	N ☐	
xxxiii	Appropriate staff in place in the unit.	Y ☐	N ☐	
D. Records Keeping		**Assessment**		**Comments**
xxxiv	There is a register available to show services and dental procedures carried out.	Y ☐	N ☐	
xxxv	A well-kept register which is maintained for all services available.	Y ☐	N ☐	
E. Dental X-Ray and Imaging		**Assessment**		**Comments**
xxxvi	There is a policy in place for acquisition, usage, calibration, maintenance, storage and disposal of equipment in the facility.	Y ☐	N ☐	
xxxvii	Policies, procedures and guidelines in place and in use as regards procurement, storage, requisition, dispensing before expiry, labeling, installation, maintenance, administration & disposal of dental radiographic materials equipment& instruments in line with International standards and Radiation Protection Board guidelines.	Y ☐	N ☐	
xxxviii	There are policies and procedures into govern the management of dental materials.	Y ☐	N ☐	
	TOTAL 76 (In this Section Yes has a value equivalent of 2)			

Hospital Representative Names_____Signature_____Date_____

A. Infrastructure		Assessment		Comments
i	There is a room set aside for dialysis services.	Y ☐	N ☐	
ii	There is a quick access to critical care.	Y ☐	N ☐	
iii	Availability or access to laboratory that can perform kidney related tests	Y ☐	N ☐	
iv	There is a designated water treatment area with proper plumbing and water purification process that is proximal to the dialysis machines.	Y ☐	N ☐	
v	There is a dedicated dialysis station for infectious patients.	Y ☐	N ☐	
B. Equipment		**Assessment**		**Comments**
vi	There is a policy in place for acquisition, usage, calibration, maintenance, storage and disposal of equipment in the facility.	Y ☐	N ☐	
vii	There is a list of equipment but not specific to dialysis machine, catheters.	Y ☐	N ☐	
viii	There is availability and usage of a renal chart.	Y ☐	N ☐	
C. Human Resource		**Assessment**		**Comments**
ix	There is a qualified renal nurse who is backed up either a nephrologists and/or a physician.	Y ☐	N ☐	
x	Infection prevention known to staff and applied.	Y ☐	N ☐	
	TOTAL 81 (In this Section Yes has a value equivalent of 9)			

Hospital Representative Names_____Signature_____Date_____

A .	Policy and Guidelines	Assessment		Comments
i	Existence of documented procedures and guidelines for identification screening , treatment and referral of clients	Y ☐	N ☐	
ii	Do you have documented, up-to-date policies and procedures to support, monitor and regulate the assessment and review process?	Y ☐	N ☐	
iii	Does the treatment and rehabilitation programme describe structured daily and weekly activities, individual and group sessions, stages or phases of treatment and related goals in a Time-defined programme?	Y ☐	N ☐	
iv	Infection prevention and control program and policies in place	Y ☐	N ☐	
B. Staffing				
v	Existence of a multidisciplinary team is in place , Medical practitioner(consultant), Nursing staff and other allied health professionals trained to deliver rehabilitation programs as appropriate	Y ☐	N ☐	
vi	Does the multidisciplinary team formally review each client's treatment progress (including psychiatric status) on a weekly basis?	Y ☐	N ☐	
C. Patient Assessment				
vii	Do you have professional staff with the relevant knowledge, skills and competencies to carry out intake assessments or screening within 24 hours, or, in the case of clients admitted with alcohol, benzodiazepine or opiate dependency, within 8 hours of Admission?	Y ☐	N ☐	
viii	Do your clients receive a comprehensive, accurate, timely assessment of their physical, psychiatric and psychosocial spiritual functioning within 72 hours of admission by a qualified and experienced professional?	Y ☐	N ☐	
ix	Do you have designated medical clinicians to deliver medical or psychiatric diagnoses?	Y ☐	N ☐	
x	Are the results of each client's comprehensive assessment reviewed by a primary counselor and the centre's multidisciplinary team within 1 week of the client's admission?	Y ☐	N ☐	
xi	Are the clients assessments recorded in the clients' case records within 24 hours?	Y ☐	N ☐	
xii	Are the results of the comprehensive assessment and the treatment plan presented and discussed at case conferences or studies?	Y ☐	N ☐	

Hospital Representative Names_____Signature_____Date_____

D.	Individualized Treatment Planning	Assessment		Comments
xiii	Do all clients have a documented, individualized treatment plan that encourages their recovery?	Y ☐	N ☐	
xiv	Do you seek informed consent from all clients prior to the onset of any treatment?	Y ☐	N ☐	
E. Counseling				
xv	Do your addiction counseling staff have the knowledge, skills and competencies to undertake the following: • Screening to establish whether the client is appropriate for the programme. • Intake – Administrative and initial assessment procedures. • Orientation of the client. • Intake and comprehensive assessment. • Treatment planning, including special needs planning (children and adolescents, the elderly, disabled). • Counseling (individual, group and family). Case management. • Crisis intervention. • Client education. • Referral • Reports and record keeping.	Y ☐	N ☐	
F. Detoxification				
xvi	Does your center have written policies, procedures and evidence on Detoxification (including voluntary withdrawal)?	Y ☐	N ☐	
G. Discharge , Re-admission and continuing care				
xvii	Are clients provided with appropriate programmes and support to enable their effective transition from a treatment Centre to their families and re-integration into their communities?	Y ☐	N ☐	
xviii	Are all clients assessed and reviewed by the multi-disciplinary team towards the end of treatment to determine their readiness for discharge and to facilitate discharge planning?	Y ☐	N ☐	
xix	Are relevant referral agencies supplied on time with a Confidential, signed and dated discharge summary to facilitate continuity of care for all clients leaving the center?	Y ☐	N ☐	
	TOTAL 57 (In this Section Yes has a value equivalent of 3)			

Hospital Representative Names_____Signature_____Date_____

A. Staffing		Self Assessment		Comments
i	There is a trained and qualified oncologist who is licensed to offer care in chemotherapy services. There is a trained and qualified radiotherapist who is licensed to offer radiotherapy services.	Y ☐	N ☐	
ii	There is multi-disciplinary team under the lead oncologist that Supports service delivery in the facility.	Y ☐	N ☐	
iii	The team formally reviews each client's treatment progress on a Scheduled basis.	Y ☐	N ☐	
B. Policies and Guidelines & licensure				
iv	There exist documented, procedures and guidelines for identification, screening, treatment, referral of patients and the Policies on cancer registry.	Y ☐	N ☐	
v	There is evidence that they are reviewed regularly based on Evidence-based clinical guidelines approved by MOH.	Y ☐	N ☐	
vi	Policies and procedures are in place to guide the safe administration of systematic therapy i.e. administration of Chemotherapeutic, biologic and immunotherapeutic agents.	Y ☐	N ☐	
vii	Guidelines on radiation safety rules and standards exist and are adhered to.	Y ☐	N ☐	
C. Safety and Risk Management				
viii	Guidelines on management of spills and cytotoxic waste are Available.	Y ☐	N ☐	
ix	Chemo preparations are transported by trained personnel in leak Proof plastic bag and sturdy containers.	Y ☐	N ☐	

Hospital Representative Names_____Signature_____Date_____

	Safety and Risk Management	Assessment		Comments
x	Preparation and administration area has a spill kit that include the following: Alkaline soap. Isopropyl alcohol. Absorbent masks. Niosh mask. 2 pairs of powder free gloves. Gown with closed front and snug cuffs. 2 cytotoxic disposal bags. Sharps container. Dust pan and brush. A pair of goggles.	Y ☐	N ☐	
xi	There is documented evidence that personnel are trained on safe handling of cytotoxic.	Y ☐	N ☐	
xii	There are guidelines on handling and storage of cytotoxic drugs.	Y ☐	N ☐	
xiii	There are protocols that deal with pre-and post-chemotherapy Management of patients to improve tolerability and reduce side effects.	Y ☐	N ☐	
xiv	There are guidelines on safe handling, storage and disposal of Brachytherapy sources.	Y ☐	N ☐	
D. Information system				
xv	There is a cancer information system integrated with the National data registry to provide and consolidate information on cancer.	Y ☐	N ☐	
E. Case Management				
xvi	There are guidelines known to all staff on assessment and pain Management.	Y ☐	N ☐	
xvii	There are guidelines to ensure patients access psychosocial Services, Nutrition services and rehabilitation services on site or on a referral basis.	Y ☐	N ☐	
F. Cancer Prevention & Screening				
xviii	There is a known policy guideline on prevention and screening of Cancer.	Y ☐	N ☐	
xix	There is an established mechanism for engaging consumers and or health care providers in cancer service delivery planning and utilization.	Y ☐	N ☐	

Hospital Representative Names_____Signature_____Date_____

G. Feedback Mechanism		Assessment		Comments
xx	Consumers and health care providers participate in the planning and implementation of quality improvement and evaluation of patient feedback data in oncology.	Y ☐	N ☐	
xxi	Mechanisms for patient/client feedback is in place.	Y ☐	N ☐	
H. Community Linkages and outreach activities		**Assessment**		**Comments**
xxii	There is documented evidence of active coordination between the health system, community service agencies and patients in cancer care.	Y ☐	N ☐	
xxiii	There is a designated staff person or resource responsible for Ensuring providers and patients make maximum use of community resources.	Y ☐	N ☐	
xxiv	There are guidelines on outreach activities for awareness and Prevention.	Y ☐	N ☐	
I. Self-Management Support		**Assessment**		**Comments**
xxv	There is an effective self-management support which are Regularly assessed and recorded in standardized form linked to a treatment plan available to practice and patient.	Y ☐	N ☐	
xxvi	Self-management is provided by clinical educators, trained in Patient empowerment and problem-solving methodologies.	Y ☐	N ☐	
xxvii	Addressing concerns of patients and families are an integral part of care and includes systematic assessment and routine involvement in peer support, counselling, groups or mentoring Programs.	Y ☐	N ☐	
	TOTAL 81 (In this Section Yes has a value equivalent of 3)			

Hospital Representative Names_____Signature_____Date_____

COVID-19 PANDEMIC HANDLING MECHANISM ESTABLISHMENT

1. **----------YES----------**

2. **…….NO----------**

TOTAL SCORE	ASSESSMENT OUTCOME
_____	SCORE_____ PERCENTAGE_____

Scores for the Various Types of Declaration

	Assessment Type	Maximum Score (Marks)	%
1.	OUTPATIENT	674	100
2.	INPATIENT & OUTPATIENT	1,091	100
3.	LABORATORY STANDALONE	260	100
4.	RADIOLOGY STANDALONE	294	100
5.	EYE UNIT STANDALONE	306	100
6.	DENTAL UNIT STANDALONE	370	100
7.	RENAL UNIT STANDALONE	275	100
8.	REHAB (DRUG & SUBSTANCE ABUSE) STANDALONE	267	100

Hospital Representative Names_____Signature_____Date_____

SECTION 21: FOR OFFICIAL USE ONLY: FINDINGS AND RECOMMENDATIONS			
KIBU ASSESSMENT TEAM			
Name		Designation	Signature
FACILITY REPRESENTATIVE(S)			

FACILITY DECLARATION

We.....and ..... of ..... (Facility)

Certify that the information provided reflects the true status of the facility and that we shall take full Responsibility of any variations herein provided.

Signature (1).....Signature (2).....

OFFICIAL STAMP

NOTE: OBSERVE THAT YOU:

i)Attach license from the Radiation Protection Board (facility with radiotherapy services)

ii) Attach license from the Pharmacy and Poisons Board, where applicable.

iii) Attach license from the Kenya Medical Laboratory & Technicians Board where applicable.

iv) Attach license from the Kenya Medical Practitioners and Dentist Board (for the facility and practitioners based in the facility

Mandatory requirement for hospitals and general practitioners

	Requirements	**Attached or not**	**Remarks**
I	Company registration certificate (registration certificate/certificate of incorporation)		
ii.	VAT/PIN Registration certificate		
iii	Valid trading license/permit		
iv	Current/Valid tax compliance certificate		
v	Availability of physical Office(evaluation team may visit to confirm)		
vi	Current operating license from professional KMPDB or any other recognized medical Body (Level 4 and above hospitals)		
vii	Dully filled health facility check list		

All copies of the above Documents MUST be attached for the health service provider to be qualified to proceed to the next level of evaluation.

S/No	**REQUIREMENTS**	**POINTS**
1	Four Specialized Doctors; I. Internal Medicine…….5 II. Paediatrics……5 III. General Surgery…….5 IV. Obstetrics & Gynaecology……..5 Attach specialist registration certificate and Practicing license.	20
2	Reference from 3 main current clients corporate bodies (fully filled) Evidence from 1 client……...5 Evidence from 2 clients…….5 Evidence from 3 clients ……5 Evidence not attached…….0	15
3	Evidence of physical office – physical location……2pts Postal address……2pts Telephone number…… 2pts Email address…… …2pts Contact person……..2pts	10
4	Credit Facility(what duration will your firm allow after invoicing to be paid) 30 Days ……3 60 Days……4 90 Days……8	15
5	Proclamation/sworn statement. Fully filled, signed and rubber stamped	10
6	Litigation history on medical negligence	10
7	Disclosure of business ownership (company profile of key personnel, disclose directors, partners or sole proprietorship) Degree Holder…….10 Diploma Holder……6	20

	Certificate Holder……4	
	TOTAL POINTS	100

THE PASS MARK FOR REGISTRATION SHALL BE 60%

(The evaluation team will verify the information given by the Health service providers and may visit the premises of the applicants for more proof as part of evaluation process)

OFFICIAL STAMP OF THE TENDERER