



# KIBABII UNIVERSITY

## PREQUALIFICATION OF SUPPLIERS: - HEALTH SERVICES PROVIDERS

HOSPITAL NAME: .....

**CATEGORY NO: PREQ/KIBU/01/2023-2025**

**CATEGORY DESCRIPTION: PROVISION OF HEALTH SERVICES: - HOSPITALS AND SPECIALISTS**

**TO:**

KIBABII UNIVERSITY

TEL NO: 0734 831 729 or 0708 085 934

EMAIL: [tenders@kibu.ac.ke](mailto:tenders@kibu.ac.ke)

WEBSITE: [www.kibu.ac.ke](http://www.kibu.ac.ke)

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## **SECTION 1- 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](http://www.kibu.ac.ke) free of charge. Applicants who download the prequalification document **MUST** email their names, contact details and tender number to: [tenders@kibu.ac.ke](mailto:tenders@kibu.ac.ke)

Completed registration documents in a plain sealed envelope, clearly marked “**PREQUALIFICATION OF HEALTH SERVICE PROVIDERS**” 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 **30<sup>th</sup> June, 2023 at 10:00 am**

**PROCUREMENT OFFICE**

**For: VICE CHANCELLOR, KIBABII UNIVERSITY**

## **SECTION 2 – 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.

- 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. Provider 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/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 **30<sup>th</sup> June, 2023 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 Law and 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 Service

2.4.2 The Prequalification application forms which are not filled out completely and submitted in the prescribed manners 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 litigation or arbitration resulting from contracts completed or uncompleted under its execution.
- 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 Prequalified
- 2.4.9 **Business premises:** The firm must have a fixed Business premise and must be registered in Kenya with certificate of Registration, Incorporation/Memorandum and articles of Association. Copies must be attached.
- 2.4.10 The firm must show proof that it has paid all its statutory obligations and have a Valid Tax Compliance Certificate.

## **SECTION 3: APPLICATION FORMS.**

### **Form I LETTER OF PREQUALIFICATION**

**Prequalification category Ref: No PREQ/KIBU/01/2023-2025**

**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 service, during the period between **1<sup>st</sup> July 2023** and **30<sup>th</sup> June 2025**
  - 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) Audited account for the last two (2) financial years OR
  - f) Bank statement of the last six (6) months (special groups)
  - g) Current operating license from professional body KMPDB or any other recognized medical Body
  - h) Specialist practicing license
  - i) Registration certificate from Professional Body

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 Stamped: .....

Witnessed by: .....

Designation: .....

Date: .....

***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:.....Desination: ..... Signature: .....

**Official rubber stamp**

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

.....  
 .....

Information submitted by.....

Title.....

Signature .....

Stamp.....

**Mandatory requirement for open category**

	<b>Requirements</b>	<b>Attached or not</b>	<b>Remarks</b>
I	Company registration certificate (registration certificate/certificate of incorporation) for hospitals		
ii.	VAT/PIN Registration certificate		
iii	Current/Valid tax compliance certificate		
iv	Availability of physical Office (evaluation team may visit to confirm) for hospitals		

**NOTE: All copies of the above Documents MUST be attached for a firm to be qualified to proceed to the next level of evaluation.**

**GENERAL REQUIREMENTS**

<b>S/No</b>	<b>REQUIREMENTS</b>	<b>POINTS</b>
1	Copies of audited accounts for the last 3 years.....20	20
2	Reference from 3 main current clients (fully filled) Evidence attached .....20 Evidence not attached.....0	20
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 .....2 60 Days.....5 90 Days.....10	10
5	Proclamation/sworn statement. Fully filled, signed and rubber stamped	10
6	Litigation history	10
7	Disclosure of business ownership (company profile disclose directors, partners or sole proprietorship)	20
	<b>TOTAL POINTS</b>	<b>100</b>

**THE PASS MARK FOR REGISTRATION SHALL BE 70%**

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

**OFFICIAL STAMP OF THE TENDERER**



# KIBU ASSESSMENT CHECKLIST FOR DECLARATION OF HEALTH FACILITIES

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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 \_\_\_\_\_ KIBU

Officer 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	
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 \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

SECTION 1: ADMINISTRATIVE INFORMATION			
<b>Facility Registration and Location</b>			
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:	
<b>Facility Details</b>			
Facility ownership	<input type="checkbox"/> Government <input type="checkbox"/> Private <input type="checkbox"/> Faith Based <input type="checkbox"/> Community		
Facility type	<input type="checkbox"/> Both In and Out Patient <input type="checkbox"/> Outpatient Only <input type="checkbox"/> Radiology Centre (Stand - alone) <input type="checkbox"/> Dental clinic (Stand-alone) <input type="checkbox"/> Ophthalmic services (Stand - alone) <input type="checkbox"/> Dialysis Centre <input type="checkbox"/> Oncology Centre <input type="checkbox"/> Rehabilitation Centre for drug & Substance Abuse <input type="checkbox"/> Other facility, Specify [ _____ ]		

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer 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 <input type="checkbox"/>	N <input type="checkbox"/>
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 <input type="checkbox"/>	N <input type="checkbox"/>
iii	There is evidence of supportive attitude towards systematic and Continuous quality improvement by the top management.	Y <input type="checkbox"/>	N <input type="checkbox"/>
iv	Is an organizational chart available and approved by management?	Y <input type="checkbox"/>	N <input type="checkbox"/>
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 <input type="checkbox"/>	N <input type="checkbox"/>
vi	Staffs treat patients with care and respect, with consideration for Patient privacy and choice.	Y <input type="checkbox"/>	N <input type="checkbox"/>
vii	Patient satisfaction surveys and patient complaints are used to Improve service quality.	Y <input type="checkbox"/>	N <input type="checkbox"/>
viii	Patients who need to be referred or transferred receive the Care and support they need to ensure continuum of care.	Y <input type="checkbox"/>	N <input type="checkbox"/>
ix	Patients who wish to complain about poor services are helped to Do so and their concerns are properly addressed.	Y <input type="checkbox"/>	N <input type="checkbox"/>
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 <input type="checkbox"/>	N <input type="checkbox"/>
xi	Services provided adhere to Ministry of Health guidelines and/or Licensing specifications and the clinical workforce is guided by current best practice.	Y <input type="checkbox"/>	N <input type="checkbox"/>
xii	Clinical guidelines are in place and are known and utilized by all Users.	Y <input type="checkbox"/>	N <input type="checkbox"/>
xiii	Referral guidelines are in place and are known and utilized by all users.	Y <input type="checkbox"/>	N <input type="checkbox"/>

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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

\*HMIS-Health Management Information System

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_



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

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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

\*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 \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
 NHIF Quality Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

A. General Policies and guidelines		Assessment		Comments
i	Pharmaceutical unit is licensed by Pharmacy & Poisons Board.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
ii	Pharmacy is supervised by a trained and registered Pharmacist or other qualified personnel appropriate for the level of care.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
iii	The facility has procedures for ordering, acquiring, storing, dispensing and disposing pharmaceutical products.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
iv	Safety procedures, protocols in relation to medication available.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
C. Record keeping and documentation		Assessment		Comments
vi	Does the pharmacy have a well-explained system for recording prescriptions?	Y <input type="checkbox"/>	N <input type="checkbox"/>	
vii	Does the pharmacy have standard operating procedures for disposal of expired drugs?	Y <input type="checkbox"/>	N <input type="checkbox"/>	
viii	Is there a daily updated inventory system showing which commodities are available?	Y <input type="checkbox"/>	N <input type="checkbox"/>	
ix	Is there documentation showing where medicines are procured?	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>TOTAL 36 (In this Section Yes has a value equivalent of 4)</b>				

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_ KIBU

Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Attach license from the Kenya Medical Laboratory Technicians & Technologist Board

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer 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 <input type="checkbox"/>	N <input type="checkbox"/>	
	Radiation safety service provider			
ii	Facility is licensed by Radiology Protection Board.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
	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 <input type="checkbox"/>	N <input type="checkbox"/>	
	Radiological examination in pregnancy			
v	Is a code of practice for pregnant women available and producible?	Y <input type="checkbox"/>	N <input type="checkbox"/>	
	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 <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
viii	There is evidence that they are reviewed regularly based on evidence-based current radiological practice.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
ix	There is a code of practice displayed next to the respective radiological devices.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
xi	Infection prevention and control policies documented and in place.	Y <input type="checkbox"/>	N <input type="checkbox"/>	

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Attach license from the Radiation Protection Board

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>SECTION 12: OTHER SUPPORT SERVICES</b>				
<b>A. Food &amp; House Keeping</b>		<b>Assessment</b>		<b>Comments</b>
	<b>Food</b>			
i	Nutritionist available in the facility.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
iii	Does the person handling food have appropriate uniform and are medically examined every 6 months	Y <input type="checkbox"/>	N <input type="checkbox"/>	
iv	There is a policy in place that ensures the food preparation, handling and storage are safe	Y <input type="checkbox"/>	N <input type="checkbox"/>	
	<b>House Keeping</b>			
v	The housekeeping service is managed to ensure the provision of a safe and effective service	Y <input type="checkbox"/>	N <input type="checkbox"/>	
	<b>Linen service management</b>			
vi	There is a policy in place to ensure there is adequate and appropriate linen to meet patients need.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
vii	The linen service is managed to ensure the provision of a safe and effective service.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>B. Mortuary</b>		<b>Assessment</b>		<b>Comments</b>
viii	There is a policy to identify, preserve, store and safely discharge bodies.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
ix	Equipment for storage and transportation of bodies meet environmental hygiene standards	Y <input type="checkbox"/>	N <input type="checkbox"/>	
x	Practices within the morgue should subscribe within the laid down procedures.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xi	Mortuary staff wear protective gear to prevent accident, injury or infection	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>TOTAL 33 (In this Section Yes has a value equivalent of 3)</b>				

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer 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 <input type="checkbox"/>	N <input type="checkbox"/>	
ii	Post exposure prophylaxis (PEP) is available to the personnel in accordance to the organizational policy.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
v	There is a policy to identify and manage patients correctly to eliminate errors.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>TOTAL 15 (In this Section Yes has a value equivalent of 5)</b>				

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer 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 <input type="checkbox"/>	N <input type="checkbox"/>	
ii	Patients'/clients' views and level of satisfaction are assessed at planned intervals e.g. through exit interviews.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
iii	Results shall be documented and acted upon, e.g. analyzed and considered in improvement plans.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
iv	Mechanisms for patient/client feedback is in place	Y <input type="checkbox"/>	N <input type="checkbox"/>	
B. Facility Outcomes		Assessment		Comments
v	The performance of health facilities is assessed on a regular basis.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
<b>TOTAL 12 (In this Section Yes has a value equivalent of 2)</b>				

Hospital Representative Names

Signature

Date

KIBU Officer 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 <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
B. Equipment				
Basic Diagnostic equipment				
iii	Eye Chart	Y <input type="checkbox"/>	N <input type="checkbox"/>	
iv	Slit Lamp	Y <input type="checkbox"/>	N <input type="checkbox"/>	
v	Direct Ophthalmoscope	Y <input type="checkbox"/>	N <input type="checkbox"/>	
vi	Tonometer	Y <input type="checkbox"/>	N <input type="checkbox"/>	
vii	Refraction Set	Y <input type="checkbox"/>	N <input type="checkbox"/>	
viii	Pen Torch	Y <input type="checkbox"/>	N <input type="checkbox"/>	
ix	Retinoscope	Y <input type="checkbox"/>	N <input type="checkbox"/>	
x	Indirect Ophthalmoscope	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xi	Applanation	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xii	Tonopen	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xiii	Lenses(20D,78D,90D)	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xiv	3 Mirror Lens	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xv	Visual Perimetry apparatus	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xvi	Ophthalmic Operating Microscope	Y <input type="checkbox"/>	N <input type="checkbox"/>	

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_



A. Infrastructure		Assessment		Comments
i	There is a room available set aside to offer critical care.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
ii	There is availability of standard ICU bed	Y <input type="checkbox"/>	N <input type="checkbox"/>	
iii	There is quick access to theatre and laboratory	Y <input type="checkbox"/>	N <input type="checkbox"/>	
B. Human Resource		Assessment		Comments
iv	Availability of staff trained in critical care including an Anesthetist.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
vi	Defibrillator	Y <input type="checkbox"/>	N <input type="checkbox"/>	
vii	Ventilator	Y <input type="checkbox"/>	N <input type="checkbox"/>	
viii	Blood Gas Analyzer.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
ix	Oxygen supply	Y <input type="checkbox"/>	N <input type="checkbox"/>	
D. Policies & Programs		Assessment		Comments
x	Standard operating procedure is in place for managing different Emergencies.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xi	Infection prevention policies in place	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>TOTAL 110 (In this Section Yes has a value equivalent of 10)</b>				

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer 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). <i>*Tick Yes if all tools are available in the tray and No if any is missing</i>	Y <input type="checkbox"/>	N <input type="checkbox"/>	
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). <i>*Tick Yes if all tools are available in the tray and No if any is missing</i>	Y <input type="checkbox"/>	N <input type="checkbox"/>	
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). <i>*Tick Yes if all tools are available in the tray and No if any is missing</i>	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxvii	Diagnostic tray i.e. (Mirror, Probe, Tweezers, Periodontal probe, Cotton rolls & Vitality test kit). <i>*Tick Yes if all tools are available in the tray and No if any is missing</i>	Y <input type="checkbox"/>	N <input type="checkbox"/>	
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). <i>*Tick Yes if all tools are available in the tray and No if any is missing</i>	Y <input type="checkbox"/>	N <input type="checkbox"/>	
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). <i>*Tick Yes if all tools are available in the tray and No if any is missing</i>	Y <input type="checkbox"/>	N <input type="checkbox"/>	

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>C. Policies and Guidelines:</b>		<b>Assessment</b>		<b>Comments</b>
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 <input type="checkbox"/>	N <input type="checkbox"/>	
xxxii	There are policies and procedures in place to govern the Management of dental materials.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxxiii	Infection prevention and control policies in place and used.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxxiii	Appropriate staff in place in the unit.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>D. Records Keeping</b>		<b>Assessment</b>		<b>Comments</b>
xxxiv	There is a register available to show services and dental procedures carried out.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxxv	A well-kept register which is maintained for all services available.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>E. Dental X-Ray and Imaging</b>		<b>Assessment</b>		<b>Comments</b>
xxxvi	There is a policy in place for acquisition, usage, calibration, maintenance, storage and disposal of equipment in the facility.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
xxxviii	There are policies and procedures into govern the management of dental materials.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>TOTAL 76 (In this Section Yes has a value equivalent of 2)</b>				

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer 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 <input type="checkbox"/>	N <input type="checkbox"/>	
ii	Do you have documented, up-to-date policies and procedures to support, monitor and regulate the assessment and review process?	Y <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
iv	Infection prevention and control program and policies in place	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>B. Staffing</b>				
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 <input type="checkbox"/>	N <input type="checkbox"/>	
vi	Does the multidisciplinary team formally review each client's treatment progress (including psychiatric status) on a weekly basis?	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>C. Patient Assessment</b>				
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 <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
ix	Do you have designated medical clinicians to deliver medical or psychiatric diagnoses?	Y <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
xi	Are the clients assessments recorded in the clients' case records within 24 hours?	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xii	Are the results of the comprehensive assessment and the treatment plan presented and discussed at case conferences or studies?	Y <input type="checkbox"/>	N <input type="checkbox"/>	

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

D. Individualized Treatment Planning		Assessment		Comments
xiii	Do all clients have a documented, individualized treatment plan that encourages their recovery?	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xiv	Do you seek informed consent from all clients prior to the onset of any treatment?	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>E. Counseling</b>				
□	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 <input type="checkbox"/>	N <input type="checkbox"/>	
□				
□				
□				
□				
□				
<b>F. Detoxification</b>				
xvi	Does your center have written policies, procedures and evidence on Detoxification (including voluntary withdrawal)?	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>G. Discharge , Re-admission and continuing care</b>				
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 <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
<b>TOTAL 57 (In this Section Yes has a value equivalent of 3)</b>				

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer 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 <input type="checkbox"/>	N <input type="checkbox"/>	
ii	There is multi-disciplinary team under the lead oncologist that Supports service delivery in the facility.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
iii	The team formally reviews each client's treatment progress on a Scheduled basis.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>B. Policies and Guidelines &amp; licensure</b>				
iv	There exist documented, procedures and guidelines for identification, screening, treatment, referral of patients and the Policies on cancer registry.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
v	There is evidence that they are reviewed regularly based on Evidence-based clinical guidelines approved by MOH.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
vii	Guidelines on radiation safety rules and standards exist and are adhered to.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>C. Safety and Risk Management</b>				
viii	Guidelines on management of spills and cytotoxic waste are Available.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
ix	Chemo preparations are transported by trained personnel in leak Proof plastic bag and sturdy containers.	Y <input type="checkbox"/>	N <input type="checkbox"/>	

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

KIBU Officer 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 <input type="checkbox"/>	N <input type="checkbox"/>	
xi	There is documented evidence that personnel are trained on safe handling of cytotoxic.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xii	There are guidelines on handling and storage of cytotoxic drugs.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xiii	There are protocols that deal with pre-and post-chemotherapy Management of patients to improve tolerability and reduce side effects.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xiv	There are guidelines on safe handling, storage and disposal of Brachytherapy sources.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>D. Information system</b>				
xv	There is a cancer information system integrated with the National data registry to provide and consolidate information on cancer.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>E. Case Management</b>				
xvi	There are guidelines known to all staff on assessment and pain Management.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xvii	There are guidelines to ensure patients access psychosocial Services, Nutrition services and rehabilitation services on site or on a referral basis.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>F. Cancer Prevention &amp; Screening</b>				
xviii	There is a known policy guideline on prevention and screening of Cancer.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xix	There is an established mechanism for engaging consumers and or health care providers in cancer service delivery planning and utilization.	Y <input type="checkbox"/>	N <input type="checkbox"/>	

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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<b>G. Feedback Mechanism</b>		<b>Assessment</b>		<b>Comments</b>
xx	Consumers and health care providers participate in the planning and implementation of quality improvement and evaluation of patient feedback data in oncology.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxi	Mechanisms for patient/client feedback is in place.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>H. Community Linkages and outreach activities</b>		<b>Assessment</b>		<b>Comments</b>
xxii	There is documented evidence of active coordination between the health system, community service agencies and patients in cancer care.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxiii	There is a designated staff person or resource responsible for ensuring providers and patients make maximum use of community resources.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
xxiv	There are guidelines on outreach activities for awareness and Prevention.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
<b>I. Self-Management Support</b>		<b>Assessment</b>		<b>Comments</b>
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 <input type="checkbox"/>	N <input type="checkbox"/>	
xxvi	Self-management is provided by clinical educators, trained in Patient empowerment and problem-solving methodologies.	Y <input type="checkbox"/>	N <input type="checkbox"/>	
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 <input type="checkbox"/>	N <input type="checkbox"/>	
<b>TOTAL 81 (In this Section Yes has a value equivalent of 3)</b>				

Hospital Representative Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

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**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 \_\_\_\_\_

KIBU Officer Names \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**SECTION 21: FOR OFFICIAL USE ONLY: FINDINGS AND RECOMMENDATIONS**

**KIBU ASSESSMENT TEAM**

Name	Designation	Signature
<b>FACILITY REPRESENTATIVE(S)</b>		

**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.ie - Directors, in-charge of Departments and sections.
- v. Copy of **Consultation fees structure** for services offered for Hospitals

- vi. Copy of **Consultation Fees Structure** for specialized services (Dental, Eye, surgical, Obstetrics/Gynecology, Dermatology etc.)
- vii. Copy of Fees Structures for Medical Laboratory Charges; include histology/cytology/Oncological etc
- viii. All Hospitals to attach **bed charges including NHIF payment** for bed occupancy per day
- ix. Copy of **services and fees** covered by NHIF

**NOTE: Kindly tick and attach copies where applicable**