
LAGOS STATE HEALTH FACILITY MONITORING AND ACCREDITATION AGENCY

# FACILITY INSPECTION TOOL FOR PRIMARY HEALTH CARE

**HEALTH FACILITY MONITORING AND ACCREDITATION AGENCY (HEFAMAA) ASSESSMENT TOOL**

| | |
|---|---|
| **Name of Establishment** | |
| **Full Address** | |
| **Ward** | |
| **Local Government Area** | |
| **Status of Establishment** | New ☐ Existing ☐ |
| **HEFAMAA Reg. Number** | |
| **Contact details of Establishment (Name, email, phone)** | |
| **Days and hours of operation** | |
| **Name and designation of person(s) interviewed** | |
| **Name of HEFAMAA Officer(s)** *Include designation* | |
| **Date of Assessment:** _____ Day/Month/Year | **Arrival time for Assessment** \|___\|___\|:\|___\|___\| H H M M<br>**Departure time after Assessment** \|___\|___\|:\|___\|___\| H H M M |

**Type of Health Establishment**

| | | | |
|---|---|---|---|
| Public Comprehensive PHC ☐ | Public Non-comprehensive PHC ☐ | Private Comprehensive PHC ☐ | Private Non-comprehensive PHC ☐ |
| Convalescent/Nursing Home ☐ | | Maternity Home ☐ | |
| Others, please specify _____ | | | |

**Other Branches:**

Any branch(es): Yes ☐ No ☐

If Yes, specify Number _____ and location(s):

i. _____
ii. _____
iii. _____
iv. _____
v. _____

## A. Services Provided

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

## B. Ownership, Governance and Registration Status

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

## C. Building and Designated Areas

| **7. Type of Building** | | |
|---|---|---|
| Purpose built ☐ | Stand alone ☐ | Shared accommodation ☐ |
| Specify type of Building | | |
| Other, please specify _____ | | |

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

| Room | Adequate in size | | Well-equipped | |
|---|---|---|---|---|
| **8.** Waiting/Reception Area | Yes ☐ | No ☐ | Yes ☐ | No ☐ |
| **9.** Consulting Room Area *Specify number of consulting rooms* _____ | Yes ☐ | No ☐ | Yes ☐ | No ☐ |
| **10.** Treatment Room Area | Yes ☐ | No ☐ | Yes ☐ | No ☐ |
| **11.** Wards | Yes ☐ | No ☐ | Yes ☐ | No ☐ |
| **12.** Labour Room | Yes ☐ | No ☐ | Yes ☐ | No ☐ |
| **13.** Ventilation | Adequate ☐ | | Inadequate ☐ | |
| **14.** Lighting | Adequate ☐ | | Inadequate ☐ | |
| **15.** Painting | Adequate ☐ | | Inadequate ☐ | |
| **Comment:** | | | | |

## D. Observation/Inpatient Care

| | | |
|---|---|---|
| **16.** Does this facility provide inpatient care | Yes ☐ | No ☐ |
| **17.** If yes, please specify the number of beds | _____ | |
| **18.** If no, please specify the number of observation beds | _____ | |
| **19.** No. of Beds *(indicate number)* | Functional _____ | Non-functional_____ |
| **20.** One metre space between beds | Yes ☐ | No ☐ |
| **21.** Mattresses and Pillows | Adequate ☐ | Inadequate ☐ |
| Covered with mackintosh | Yes ☐ | No ☐ |
| **Comment:** | | |

## E. Maternity Unit

| | | |
|---|---|---|
| **22.** Delivery bed with stirrups (Specify number):___ | Functional ☐ | Non-functional ☐ |
| **23.** Angle Poise Lamp (Specify number):___ | Functional ☐ | Non-functional ☐ |
| **24.** Resuscitaire (Specify number):___ (Includes: Mucus extractor, Ambu Bag, Flat Table, Lamp ) | Functional ☐ | Non-functional ☐ |
| **25.** Suction machine | | |
| Manual (Specify number):___ | Functional ☐ | Non-functional ☐ |
| Automatic (Specify Number):___ | Functional ☐ | Non-functional ☐ |
| **26.** Suturing materials | Available ☐ | Not Available ☐ |

**27. Oxygen** ***(tick the applicable - sighted)*** Available ☐ Not Available ☐

a. Cylinder with all accessories ☐
*(Gauge, Flow Meter, Masks, tubes)*

b. Oxygen concentrator ☐

**28.** Pinard Fetoscope Yes ☐ No ☐ Sonicaid Yes ☐ No ☐

***29.*** Does the facility possess the following maternal life-saving drugs and commodities?

Magnesium sulphate Yes ☐ No ☐ Misoprostol Yes ☐ No ☐

Anti-shock garment Yes ☐ No ☐

**30.** Delivery packs are available *(minimum of 3) see Annex 2* Yes ☐ No ☐

**31.** Baby cots *Specify number functional*:_____ Functional ☐ Non-functional ☐

**32.** Infant ID bracelets are available Yes ☐ No ☐

**Comment**

## F. Emergency and Referral Services

**33.** Clinical and nursing personnel are trained on BLS Yes ☐ No ☐

**34.** Facility has skilled personnel trained on MNCH related emergencies *(use of partograph, anti-shock garment, misoprostol and Mag. Sulphate)* Yes ☐ No ☐

**35.** Emergency equipment are available and functional Yes ☐ No ☐

Oxygen cylinder /concentrator ☐ Ambubag Paediatric ☐ Ambubag Adult ☐

Suction machine ☐ Nebulizer ☐ Defibrillator ☐

**36.** Contents of Emergency Tray Adequate ☐ Inadequate ☐

***(check functionality (Good or Bad) and expiry)*** – **see Annex 1 for List**

***List of emergency equipment and commodities sighted and functionality (Good or Bad) and expired***

| | |
|---|---|
| ***i.*** | ***ii.*** |
| ***iii.*** | ***iv.*** |
| ***v.*** | ***vi.*** |
| ***vii.*** | ***viii.*** |
| ***ix.*** | ***x.*** |

**37.** Is there an established referral system in place? Yes ☐ No ☐

**38.** Are ambulance services readily accessible? Yes ☐ No ☐

**Comment**

## G. Sterilization / Infection Control

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

## H. Hand Washing Facilities

**Check adequacy of handwashing facilities:**
*Water supply, liquid soap (with manual applicator), drying technique (single-use hand towels)*

| | | |
|---|---|---|
| **45.** Treatment Room | Adequate ☐ | Inadequate ☐ |
| **46.** Consulting Room | Adequate ☐ | Inadequate ☐ |
| **47.** Wards | Adequate ☐ | Inadequate ☐ |
| **48.** Health Records | Adequate ☐ | Inadequate ☐ |
| **49.** Labour room | Adequate ☐ | Inadequate ☐ |
| **50.** Laboratory | Adequate ☐ | Inadequate ☐ |

**Comment:**

## I. Health Records

| | | | |
|---|---|---|---|
| **51.** Indicate if records are Describe if it is both _____ | Paper-based ☐ | Digital ☐ | Both ☐ |
| **52.** Are records facilities adequate: | | | |
| Secure Location | Yes ☐ | No ☐ | |
| Shelving | Yes ☐ | No ☐ | |
| Filing | Yes ☐ | No ☐ | |
| **53.** Are NHMIS registers available | Yes ☐ | No ☐ | |
| **54.** Is HMIS data submitted monthly | Yes ☐ | No ☐ | |
| **55.** STAFF (Number) | medical record officer ☐ | Others ☐ | |

**Comment:**

**J. Diagnostic Services**

**Laboratory**

**56.** Type of Laboratory:

PHC lab ☐ Commercial (Standalone) ☐

***57.*** Laboratory investigations (*Specify tests)*

| | | | |
|---|---|---|---|
| ***i.*** | ***PCV.*** | ***ii.*** | ***Urinalysis.*** |
| ***iii.*** | ***Rapid Test Kits (Malaria, HIV, Hepatitis).*** | ***iv.*** | ***Simple Microscopy for Sputum, Stool and Urine.*** |
| ***v.*** | ***ESR.*** | ***vi.*** | ***Blood Sugar,*** |
| | | ***vii.*** | ***Blood Group.*** |
| ***viii.*** | ***Genotype.*** | ***ix.*** | ***Full blood count*** |

***Others (please specify):_____***

**58.** Personnel in Charge:

Med Lab Scientist/practicing license ☐ Med Lab Tech/practicing license ☐

Others-please specify:

_____

**59.** Lab Equipment *(adequacy based on scope of services)* Available ☐ Not available ☐

**List lab equipment sighted and functionality (Good or Bad)**

| | |
|---|---|
| ***i. Micro haematocrit centrifuge*** | ***ii. Microscope*** |
| ***iii. Bucket centrifuge*** | ***iv. Counting chamber*** |
| ***v. Glucometer*** | ***vi. Pipette*** |
| ***vii. Glassware*** | ***viii. Gene xpert*** |
| ***ix. CD4 machine*** | ***x. Refrigerator*** |
| ***xi. Incubator*** | ***xii. Autoclave*** |
| ***xiii. Phlebotomy Stand*** | ***xiv. Thermometer*** |
| ***xv. Temperature register/chart*** | ***xvi. Others (please specify): _____*** |

_____

| | | |
|---|---|---|
| **60.** Power Supply | Adequate ☐ | Inadequate ☐ |
| **61.** Waste Management | Adequate ☐ | Inadequate ☐ |
| **62.** Illumination | Adequate ☐ | Inadequate ☐ |
| **63.** Water Supply | Adequate ☐ | Inadequate ☐ |
| **64.** PPE | Adequate ☐ | Inadequate ☐ |

**Comment:**

**Ultrasound Services**

**65.** Does the facility provide ultrasound services Yes ☐ No ☐

**66.** Who provides ultrasound services:

Sonographer ☐ Sonologist ☐ Radiologist ☐

Others, please specify _____

| Comment |
|---|
| |

## K. Medication Management

| | | |
|---|---|---|
| **67.** Is there a functional pharmacy or dispensary | Yes ☐ | No ☐ |
| **68.** Specify if it is a pharmacy or dispensary | _____ | |
| **69.** Indicate Personnel in Charge: | Pharmacist ☐ | Pharm. Technician ☐ |
| **70.** Is there a Counselling Area | Yes ☐ | No ☐ |
| **71.** Availability of shelves and pallets | Yes ☐ | No ☐ |
| **72.** Well arranged with adequate ventilation (Adequate shelves and pallets) | Yes ☐ | No ☐ |
| **73.** Availability of a secured drug store | Yes ☐ | No ☐ |
| **74.** Is there an air conditioning unit in the drug store? | Yes ☐ | No ☐ |
| **75.** Availability of a dispensary | Yes ☐ | No ☐ |
| **76.** Is the size of the dispensary adequate (Minimum of $30m^2$) | Yes ☐ | No ☐ |
| **77.** Availability of fan in the dispensary | Yes ☐ | No ☐ |
| **78.** Is there a compounding area in the dispensary | Yes ☐ | No ☐ |
| **79.** Illumination | Adequate ☐ | Inadequate ☐ |
| **80.** Is there a Drug Formulary (EMDEX, BNF etc) | Yes ☐ | No ☐ |
| **81.** Room temperature charts are available | Yes ☐ | No ☐ |
| **82.** Is there a functional fridge | Yes ☐ | No ☐ |
| **83.** Are Fridge temperature charts available (Including for Vaccines) | Yes ☐ | No ☐ |
| **84.** Is there a lockable DDA cupboard and register | Yes ☐ | No ☐ |
| **85.** Disposal of expired drugs and consumables | Adequate ☐ | Inadequate ☐ |
| **86.** Appropriate use of PPEs | Yes ☐ | No ☐ |
| **87.** Availability of Fire Fighting equipment | Yes ☐ | No ☐ |
| **Comment:** | | |

## L. Catering Services

| | | |
|---|---|---|
| **88.** Are catering services provided | Yes ☐ | No ☐ |
| If yes, | In-house ☐ | Outsourced ☐ |

| | | |
|---|---|---|
| **89.** Is the kitchen clean<br>(Walls, floor, utensils, extractor, door with net, pest control) | Yes ☐ | No ☐ |
| **90.** Is the kitchen well-ventilated | Yes ☐ | No ☐ |
| **91.** Is the kitchen well equipped<br>*(check cooking equipment, utensils, storage of perishable and non-perishable food, refrigeration)* | Yes ☐ | No ☐ |
| **92.** Fire blanket and fire extinguisher sighted | Yes ☐ | No ☐ |
| **93.** Fire Alarm is available and functional | Yes ☐ | No ☐ |
| **94.** Evidence of food handlers test<br>(Salmonella, Staph Aureus, TB, HBsAg, Stool Test) | Yes ☐ | No ☐ |
| **Comment:** | | |

**M. Environment and Amenities**

| | | |
|---|---|---|
| **95.** General Ventilation | Adequate ☐ | Inadequate ☐ |
| **96.** Illumination | Adequate ☐ | Inadequate ☐ |
| **97.** Main source of electricity | PHCN ☐ | Others ☐ |
| *Other, please specify* _____ | | |
| **98.** Is there alternate power supply | Yes ☐ | No ☐ |
| **99.** If yes*, tick applicable option(s)* | Generator ☐ Inverter ☐ | Solar ☐ |
| *Others sources, please specify* _____ | | |
| **100.** Is there potable water supply | Yes ☐ | No ☐ |
| **101.** Source(s) of water | | |
| Pipe borne ☐ Borehole ☐ Well ☐ | | |
| Others_____ | | |
| **102.** No of Toilets | Available:_____ | Functional:_____ |
| *Cistern that flushes* | | |
| **103.** Number of toilets available for staff | Adequate ☐ | Inadequate ☐ |
| **104.** Number of toilets for OPD | Adequate ☐ | Inadequate ☐ |
| ***105.*** Number of toilets for Inpatients | Adequate ☐ | Inadequate ☐ |
| **106.** Wash hand basin with running water | Yes ☐ | No ☐ |
| **107.** Cleaning agents and disinfectant | Yes ☐ | No ☐ |
| **108.** Anti-bacterial hand wash | Yes ☐ | No ☐ |
| **109.** Toilet roll | Yes ☐ | No ☐ |
| **110.** Pedal bin lined with nylon | Yes ☐ | No ☐ |
| **111.** Serviette/Single-use hand towel | Yes ☐ | No ☐ |
| **112.** Shower with running water | Yes ☐ | No ☐ |
| **113.** Is there an external drainage- (house drain) | Yes ☐ | No ☐ |
| **114.** Is the drainage covered | Yes ☐ | No ☐ |
| **Comments:** | | |

**Waste Management**

| | | |
|---|---|---|
| Registered with: | | |
| **115.** LAWMA PSP | Yes ☐ | No ☐ |
| **116.** LAWMA Medical | Yes ☐ | No ☐ |
| **117.** Correct bin and sharps container used | Yes ☐ | No ☐ |
| **118.** Proper waste segregation observed | Yes ☐ | No ☐ |
| **119.** Use of appropriate coloured bags | Yes ☐ | No ☐ |
| *(Tick those available)* | | |
| Black ☐ Yellow ☐ Red ☐ Brown ☐ Safety sharp box ☐ | | |
| **120.** Final Collection Point | Adequate ☐ | Inadequate ☐ |

| | | |
|---|---|---|
| **121.** How often is waste collected by LAWMA (Please specify)<br>Domestic Waste : _____<br><br>Medical Waste : _____ | | |
| **122.** Domestic Waste management | Adequate ☐ | Inadequate ☐ |
| **123.** Medical Waste management | Adequate ☐ | Inadequate ☐ |
| **Comment:** | | |

**N. Fire Safety**

| | | |
|---|---|---|
| **124.** Fire Service Certification | Available ☐ | Not Available ☐ |
| **125.** Fire-fighting equipment | Yes ☐ | No ☐ |
| **126.** Service History | Yes ☐ | No ☐ |
| **127.** Two readily accessible and labelled exits seen | Yes ☐ | No ☐ |
| **128.** Muster/Assembly Point | Available ☐ | Not Available ☐ |
| **Comment:** | | |

**O. Staffing**

| | | |
|---|---|---|
| **129.** Facility has a Quality Improvement Program | Yes ☐ | No ☐ |
| **130.** Regular update training for health personnel | Yes ☐ | No ☐ |
| **131.** Duty Roster for health personnel available | Yes ☐ | No ☐ |
| **132.** Adequate number of qualified health personnel<br>If No, state the personnel type _____<br>_____ | Yes ☐ | No ☐ |

**Health Centre *(Indicate number of personnel)***

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

**Maternity Centre**

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

**Nursing/Convalescent Home**

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

**STAFF COMPLEMENT FORM**

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

**Annex 1: Standard Emergency Tray List**

**Resuscitation Equipment**

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

**Evaluation Equipment**

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

**Treatment Equipment**

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

**Drugs**

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

**Annex 2: Sterile Delivery Pack**

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