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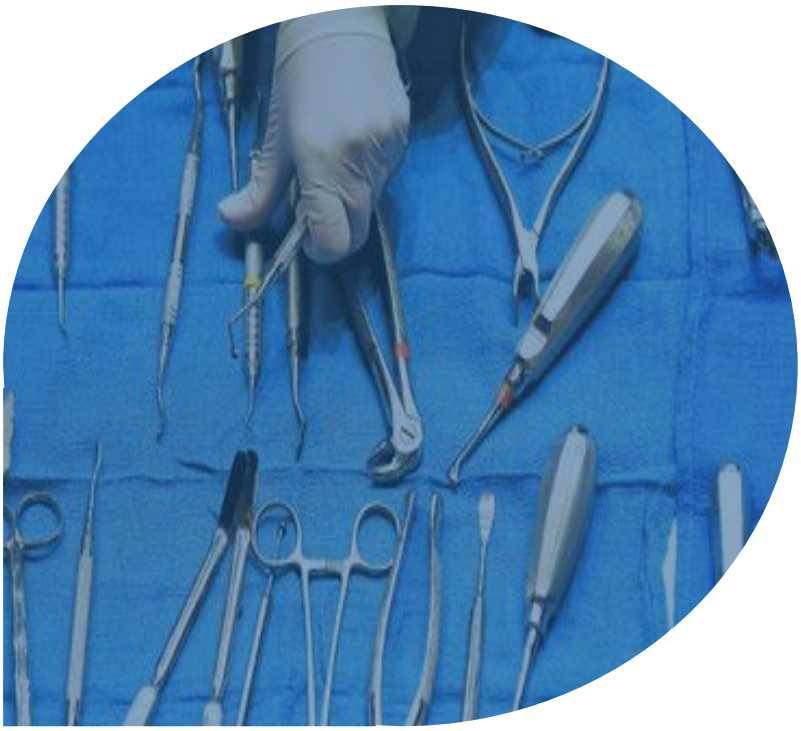
Ensuring quality and safety in health care



Midwife Obstetric Unit

v1.3

Regulatory CHC inspection tool

Facility: Date:

- **Tool Name:** Regulatory CHC Inspection tool v1.3 - Final
- **HEs Type:** CHC
- **Sector:** Public
- **Specialization:** CHC
- **Created By:** Health Standards Development and Training

Midwife Obstetric Unit (MOU)

Domain 5.1 USER RIGHTS

Sub Domain 5.1.1 4 User information

Standard 5.1.1.1 4(1) The health establishment must ensure that users are provided with adequate information about the health care services available at the health establishment and information about accessing those services.

Criterion 5.1.1.1.1 4(2)(a)(iv) The health establishment must provide users with information relating to the complaints, compliments and suggestions management system.

5.1.1.1.1.1 The complaints toolkit is available.

Assessment type: Observation - **Risk rating:** Essential measure

Check whether the complaint toolkit is available and complies with the aspects listed below. In the CHC where the units are in close proximity the complaints toolkit can be shared by various units. Toolkit must be assessed in the unit where it is located. Score 1 if compliant and score 0 if not compliant.

Score	Comment

Aspects	Score	Comment
1. The complaints box is visibly placed in the health establishment		
2. The complaints box is lockable.		
3. The complaints box is mounted to the wall		
4. Standardized complaints forms are readily available next to the box or upon request.		
5. The poster describing the process for lodging a complaint is posted next to or nearby the complaints box.		
6. The poster describing the process for lodging a complaint is available in at least two official languages commonly spoken in the area.		

Sub Domain 5.1.2 5 Access to care

Standard 5.1.2.1 5(1) The health establishment must ensure that users are attended to in a manner which is consistent with the nature and severity of their health condition.

Criterion 5.1.2.1.1 5(2)(b) The health establishment must ensure access to emergency medical transport for users requiring urgent transfer to another health establishment, and that they are accompanied by a health care provider.

5.1.2.1.1.1 Emergency medical service contact number(s) are displayed in areas where telephones are available.

Assessment type: Observation - **Risk rating:** Vital measure

Check whether emergency contact numbers are displayed next to each telephone. It could be 112 and other numbers. (The requirement will be met if only 112 is displayed as calls can be re-routed from this service. If the health establishment utilises official mobile phones score positive if the emergency numbers are displayed within the unit.
Not applicable: Never

Score	Comment

5.1.2.1.1.2 A documented record detailing emergency transport requests is kept.

Assessment type: Document - **Risk rating:** Essential measure
Request the register or book or file or computer record where this information is recorded. Score 1 if the aspect is documented and 0 if it is not documented.

Score	Comment

Aspects	Score	Comment
1. Date of the request		
2. Details of the user for whom the request was made. Explanatory note: Details must include Name and Surname of user, Date of birth or age or identity number or passport number.		
3. Reason for referral		
4. The time the ambulance was requested		
5. The time the ambulance arrived		

Standard 5.1.2.2 5(3) The health establishment must maintain a system of referral as established by the responsible authority.
Criterion 5.1.2.2.1 5(4)(a) The health establishment must ensure that users are provided with information relating to their referral to another health establishment.

5.1.2.2.1.1 Health care providers are able to explain what information they provide to users being referred.

Assessment type: Staff interview - **Risk rating:** Essential measure
Interview three health care providers to establish if they are aware of the information that must be provided to users who are referred. Score 1 if the health care provider provides correct answers and 0 if the health care provider does not provide the correct answers.

Score	Comment

Unit 1 Health care provider 1

Aspects	Score	Comment
1. Reason for referral		
2. The health establishment or service or department referred to		

3. Follow up action post referral visit (e.g., return to CHC)		

Unit 2 Health care provider 2

Aspects	Score	Comment
1. Reason for referral		
2. The health establishment or service or department referred to		
3. Follow up action post referral visit (e.g., return to CHC)		

Unit 3 Health care provider 3

Aspects	Score	Comment
1. Reason for referral		
2. The health establishment or service or department referred to		
3. Follow up action post referral visit (e.g., return to CHC)		

Domain 5.2 CLINICAL GOVERNANCE AND CLINICAL CARE

Sub Domain 5.2.1 6 User health records and management

Standard 5.2.1.1 6(1) The health establishment must ensure that health records of health care users are protected, managed and kept confidential in line with section 14, 15 and 17 of the Act.

Criterion 5.2.1.1.1 6(2)(b) The health establishment must ensure confidentiality of health records.

5.2.1.1.1.1 Confidentiality of health records is maintained.

Assessment type: Observation - **Risk rating:** Vital measure

Observe how user health records are managed in various areas within the health establishment (this will include but not limited to public areas, clinical areas) and determine whether unauthorised individuals would not be able to access the information in the health records. This will include the health records of users waiting to be seen, users who have already been seen but their records have not yet been returned to the records storage area/room, health records being used for clinical audit or other administrative purposes, or health records outside the records storage area/room for any other reason. Such records should be kept in a manner which safeguards against unauthorised access to the content of the record. Electronic records must be safeguarded with passwords.

Not applicable: Never

Score	Comment

Standard 5.2.1.2 6(3) The health establishment must create and maintain a system of health records of users in accordance with the requirements of section 13 of the Act.

Criterion 5.2.1.2.1 6(4)(a) The health establishment must record the biographical data of the user and the identification and contact information of the user and his or her next of kin.

5.2.1.2.1.1 Biographical, demographic and contact information of the user is recorded in the Maternity Case Record.

Assessment type: Patient record audit - **Risk rating:** Essential measure

Check whether user health records contain the required details as listed below. Select three health records of users seen at the time of inspection. Score 1 if detail is recorded and 0 if detail is not recorded.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. Name and surname		
2. User file number		
3. Health establishment name		
4. ID/refugee/passport number or date of birth		
5. Residential address		
6. Personal contact details		
7. Name and surname of parents or guardian (if user is a minor)		
8. Next of kin contact details		

Unit 2 User health record 2

Aspects	Score	Comment
1. Name and surname		
2. User file number		
3. Health establishment name		
4. ID/refugee/passport number or date of birth		
5. Residential address		
6. Personal contact details		
7. Name and surname of parents or guardian (if user is a minor)		
8. Next of kin contact details		

Unit 3 User health record 3

Aspects	Score	Comment
1. Name and surname		
2. User file number		
3. Health establishment name		
4. ID/refugee/passport number or date of birth		
5. Residential address		
6. Personal contact details		
7. Name and surname of parents or guardian (if user is a minor)		
8. Next of kin contact details		

Criterion 5.2.1.2.2 6(4)(b) The health establishment must record information relating to the examination and health care interventions of users.

5.2.1.2.2.1 The antenatal clinical assessment and management plan for the user is recorded in the Maternity Case Record.

Assessment type: Patient record audit - **Risk rating:** Vital measure
Select three records of users seen at the time of inspection and check whether the aspects listed below are recorded. Score 1 if the detail is recorded and 0 if the detail is not recorded.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. Obstetric and neonatal history		
2. Medical and general history		
3. Examination		
4. Vaginal examination		
5. Investigations		
6. Gestational Age		
7. Mental Health		
8. Birth Companion		
9. Counselling		
10. Future Contraception		
11. Gestational growth chart completed at each visit		
12. Symphysis fundal height (SFH) recorded at each visit from 20 weeks gestation.		
13. Maternal blood pressure recorded at each visit		
14. Urine dipstick recorded at each visit.		
15. Fetal movements recorded at each visit from 28 weeks gestation.		
16. Fetal presentation after 36 weeks recorded at each visit from 36 weeks gestation.		
17. Date of entries		
18. Name of Health care provider recorded		

Unit 2 User health record 2

Aspects	Score	Comment
1. Obstetric and neonatal history		
2. Medical and general history		

3. Examination		
4. Vaginal examination		
5. Investigations		
6. Gestational Age		
7. Mental Health		
8. Birth Companion		
9. Counselling		
10. Future Contraception		
11. Gestational growth chart completed at each visit		
12. Symphysis fundal height (SFH) recorded at each visit from 20 weeks gestation.		
13. Name of Health care provider recorded		
14. Urine dipstick recorded at each visit.		
15. Fetal movements recorded at each visit from 28 weeks gestation.		
16. Fetal presentation after 36 weeks recorded at each visit from 36 weeks gestation.		
17. Date of entries		
18. Name of Health care provider recorded		

Unit 3 User health record 3

Aspects	**Score**	**Comment**
1. Obstetric and neonatal history		
2. Medical and general history		
3. Examination		
4. Vaginal examination		
5. Investigations		
6. Gestational Age		
7. Mental Health		
8. Birth Companion		
9. Counselling		
10. Future Contraception		
11. Gestational growth chart completed at each visit		
12. Symphysis fundal height (SFH) recorded at each visit from 20 weeks gestation.		
13. Name of Health care provider recorded		
14. Urine dipstick recorded at each visit.		

15. Fetal movements recorded at each visit from 28 weeks gestation.		
16. Fetal presentation after 36 weeks recorded at each visit from 36 weeks gestation.		
17. Date of entries		
18. Name of Health care provider recorded		

5.2.1.2.2.2 Monitoring of women in labour is standardised in accordance with national guidelines.

Assessment type: Patient record audit - **Risk rating:** Vital measure

Select the completed labour records of three users who have delivered at the time of inspection and verify whether each of the aspects listed below has been recorded. Score 1 if the aspect is recorded and 0 if not recorded. Score not applicable for aspects not applicable to users whose records are being audited. Users admitted in active phase of labour would not have information recorded.

Score	**Comment**

Unit 1 User health record 1

Aspects	**Score**	**Comment**
Observation chart when the diagnosis of labour is doubtful completed comprehensively (Where applicable).		
1. Assessment date		
2. Assessment time		
3. Assessment of mother		
4. Assessment of fetus		
5. Vaginal examination		
6. Discharge checklist completed (where applicable)		
7. Plan (if not discharged)		
Labour Initial Assessment when the diagnosis of labour is certain completed comprehensively.		
8. Assessment date		
9. Assessment time		
10. Time of admission		
11. Antenatal information		
12. Main complaints		
13. General examination		
14. Abdominal Examination		

15. Vaginal Examination		
16. Risk factors		
17. Summary of diagnosis		
18. Details of healthcare provider who assessed the user		

Unit 2 User health record 2

Aspects	Score	Comment
Observation chart when the diagnosis of labour is doubtful completed comprehensively (Where applicable).		
1. Assessment date		
2. Assessment time		
3. Assessment of mother		
4. Assessment of fetus		
5. Vaginal examination		
6. Discharge checklist completed (where applicable)		
7. Plan (if not discharged)		
Labour Initial Assessment when the diagnosis of labour is certain completed comprehensively.		
8. Assessment date		
9. Assessment time		
10. Time of admission		
11. Antenatal information		
12. Main complaints		
13. General examination		
14. Abdominal Examination		
15. Vaginal Examination		
16. Risk factors		
17. Summary of diagnosis		
18. Details of healthcare provider who assessed the user		

Unit 3 User health record 3

Aspects	Score	Comment

Observation chart when the diagnosis of labour is doubtful completed comprehensively (Where applicable).		
1. Assessment date		
2. Assessment time		
3. Assessment of mother		
4. Assessment of fetus		
5. Vaginal examination		
6. Discharge checklist completed (where applicable)		
7. Plan (if not discharged)		
Labour Initial Assessment when the diagnosis of labour is certain completed comprehensively.		
8. Assessment date		
9. Assessment time		
10. Time of admission		
11. Antenatal information		
12. Main complaints		
13. General examination		
14. Abdominal Examination		
15. Vaginal Examination		
16. Risk factors		
17. Summary of diagnosis		
18. Details of healthcare provider who assessed the user		

5.2.1.2.2.3 The assessment and management of labour is comprehensively recorded in the maternity case record.

Assessment type: Patient record audit - **Risk rating:** Vital measure
Select the completed partograms and labour records of three users who have given birth and verify whether each of the aspects listed below have been recorded in accordance with national guidelines. Score 1 if the aspect is recorded and 0 if not recorded. Score not applicable for aspects that is not relevant to users whose records are being audited.

Score	**Comment**

Unit 1 User health record 1

Aspects	Score	Comment
Partogram		
1. Obstetric information (e.g., Gravidity, Parity, Gestation)		
2. Foetal condition		
3. Progress of labour		
4. Contractions		
5. Maternal condition		
6. Time of assessment		
7. Management or medication or I.V Fluids		
8. Pain relief administered		
9. Signature and designation of clinician		
Summary of labour		
10. Labour from full dilation to delivery		
11. Summary of duration of labour		
12. Pain relief		
13. Neonatal details		
14. Third stage of labour: Placenta, Membranes and Cord		
15. Fourth stage (First two hours after delivery)		

Unit 2 User health record 2

Aspects	Score	Comment
Partogram		
1. Obstetric information (e.g., Gravidity, Parity, Gestation)		
2. Foetal condition		
3. Progress of labour		
4. Contractions		
5. Maternal condition		
6. Time of assessment		
7. Management or medication or I.V Fluids		

8. Pain relief administered		
9. Signature and designation of clinician		
Summary of labour		
10. Labour from full dilation to delivery		
11. Summary of duration of labour		
12. Pain relief		
13. Neonatal details		
14. Third stage of labour: Placenta, Membranes and Cord		
15. Fourth stage (First two hours after delivery)		

Unit 3 User health record 3

Aspects	**Score**	**Comment**
Partogram		
1. Obstetric information (e.g., Gravidity, Parity, Gestation)		
2. Foetal condition		
3. Progress of labour		
4. Contractions		
5. Maternal condition		
6. Time of assessment		
7. Management or medication or I.V Fluids		
8. Pain relief administered		
9. Signature and designation of clinician		
Summary of labour		
10. Labour from full dilation to delivery		
11. Summary of duration of labour		
12. Pain relief		
13. Neonatal details		
14. Third stage of labour: Placenta, Membranes and Cord		
15. Fourth stage (First two hours after delivery)		

5.2.1.2.2.4 The assessment of newborn is comprehensively documented.

Assessment type: Patient record audit - **Risk rating:** Vital measure

Select the completed labour health records for three users who have delivered at the time of inspection and verify whether each of the aspects listed below has been recorded. Score 1 if the aspect is recorded and 0 if not recorded. Score not applicable for aspects not relevant to the user whose records are being audited.

Score	Comment

Unit 1 User Health record 1

Aspects	Score	Comment
1. First examination of neonate		
2. Examined by documented		
3. Checked by documented		
4. Date and time		
Assessment of newborn recorded comprehensively		
5. Gender		
6. Birth weight		
7. Head circumference		
8. Gestational age score		
9. Resuscitation (where applicable)		
10. Routine care		
11. Mode of delivery		
12. Treatment given		
13. Risk factors to baby		
14. Problems during newborn period		
15. Preventative care		
16. Feeding		
17. Follow up plans		
18. Identification		

Unit 2 User Health record 2

Aspects	Score	Comment
1. First examination of neonate		
2. Examined by documented		
3. Checked by documented		
4. Date and time		

Assessment of newborn recorded comprehensively		
5. Gender		
6. Birth weight		
7. Head circumference		
8. Gestational age score		
9. Resuscitation (where applicable)		
10. Routine care		
11. Mode of delivery		
12. Treatment given		
13. Risk factors to baby		
14. Problems during newborn period		
15. Preventative care		
16. Feeding		
17. Follow up plans		
18. Identification		

Unit 3 User Health record 3

Aspects	**Score**	**Comment**
1. First examination of neonate		
2. Examined by documented		
3. Checked by documented		
4. Date and time		
Assessment of newborn recorded comprehensively		
5. Gender		
6. Birth weight		
7. Head circumference		
8. Gestational age score		
9. Resuscitation (where applicable)		
10. Routine care		

11. Mode of delivery		
12. Treatment given		
13. Risk factors to baby		
14. Problems during newborn period		
15. Preventative care		
16. Feeding		
17. Follow up plans		
18. Identification		

5.2.1.2.2.5 The postnatal assessment of the mother and baby is documented.

Assessment type: Patient record audit - **Risk rating:** Vital measure
Select three maternity case records of users who have delivered at the time of inspection and verify whether puerperium notes have been documented. Score 1 if notes are recorded and 0 if not recorded.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. Notes for mother		
2. Notes for baby		
3. Date of entry		
4. Time of entry		
5. Details of healthcare provider		

Unit 2 User health record 2

Aspects	Score	Comment
1. Notes for mother		
2. Notes for baby		
3. Date of entry		
4. Time of entry		
5. Details of healthcare provider		

Unit 3 User health record 3

Aspects	Score	Comment

1. Notes for mother		
2. Notes for baby		
3. Date of entry		
4. Time of entry		
5. Details of healthcare provider		

Standard 5.2.1.3 6(5) The health establishment must have a formal process to be followed when obtaining informed consent from the user.

Criterion 5.2.1.3.1 6 A documented procedure which describes the information to be collected and discussed during the process to obtain informed consent is implemented, in accordance with Chapter 2 of the National Health Act(Section 7).

5.2.1.3.1.1 Informed consent forms are completed correctly.

Assessment type: Patient record audit - **Risk rating:** Vital measure

Select three completed informed consent forms of users who were seen in the health establishment at the time of inspection or records from the previous month if health records are not available at the time of inspection and verify whether the aspects listed below are recorded. Score 1 if the aspect is recorded and score 0 if the aspect is not recorded.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. User's full name(s) and surname are written on the consent form		
2. The user's age or date of birth or identity number is documented in the consent form		
3. The exact nature of the procedure or treatment is written on the consent form		
4. The name of the person who signed the consent is documented (it could be the parent or guardian). Explanatory note: This aspect is not applicable where the user signed the consent form		
5. The consent form is signed by the user or parent/guardian. Explanatory note: Signatory providing consent was legally entitled to give informed consent. As described in the National Health Act, this may be a person authorised by the court (e.g., a curator), or in order of priority, the user's spouse, partner, parent, grandparent, major child, or brother or sister. In an emergency, lifesaving procedures may be authorised by the health care provider, if “the treatment is limited to what is immediately necessary to save life or avoid significant deterioration in the user's health” HPCSA, Booklet 9. In the case of a child, the age to give consent is over 12 years in accordance with sections 129(2)(a)(b) and 129(3)(a)(b)(c) of the Children’s Act, No 38 of 2005		
6. The consent form is signed by the health care provider		
7. The consent form is dated.		

Unit 2 User health record 2

Aspects	Score	Comment
1. User's full name(s) and surname are written on the consent form		
2. The user's age or date of birth or identity number is documented in the consent form		
3. The exact nature of the procedure or treatment is written on the consent form		
4. The name of the person who signed the consent is documented (it could be the parent or guardian). Explanatory note: This aspect is not applicable where the user signed the consent form		
5. The consent form is signed by the user or parent/guardian. Explanatory note: Signatory providing consent was legally entitled to give informed consent. As described in the National Health Act, this may be a person authorised by the court (e.g., a curator), or in order of priority, the user's spouse, partner, parent, grandparent, major child, or brother or sister. In an emergency, lifesaving procedures may be authorised by the health care provider, if “the treatment is limited to what is immediately necessary to save life or avoid significant deterioration in the user's health” HPCSA, Booklet 9. In the case of a child, the age to give consent is over 12 years in accordance with sections 129(2)(a)(b) and 129(3)(a)(b)(c) of the Children’s Act, No 38 of 2005		
6. The consent form is signed by the health care provider		
7. The consent form is dated.		

Unit 3 User health record 3

Aspects	Score	Comment
1. User's full name(s) and surname are written on the consent form		
2. The user's age or date of birth or identity number is documented in the consent form		
3. The exact nature of the procedure or treatment is written on the consent form		
4. The name of the person who signed the consent is documented (it could be the parent or guardian). Explanatory note: This aspect is not applicable where the user signed the consent form		
5. The consent form is signed by the user or parent/guardian. Explanatory note: Signatory providing consent was legally entitled to give informed consent. As described in the National Health Act, this may be a person authorised by the court (e.g., a curator), or in order of priority, the user's spouse, partner, parent, grandparent, major child, or brother or sister. In an emergency, lifesaving procedures may be authorised by the health care provider, if “the treatment is limited to what is immediately necessary to save life or avoid significant deterioration in the user's health” HPCSA, Booklet 9. In the case of a child, the age to give consent is over 12 years in accordance with sections 129(2)(a)(b) and 129(3)(a)(b)(c) of the Children’s Act, No 38 of 2005		
6. The consent form is signed by the health care provider		
7. The consent form is dated.		

Standard 5.2.1.4 6(6) The health establishment must issue a discharge report to users in accordance with section 10 of the Act.
Criterion 5.2.1.4.1 6 Comprehensive discharge reports must be provided to users to ensure continuity of care.

5.2.1.4.1.1 Discharge summaries are available in user health records.

Assessment type: Patient record audit - **Risk rating:** Vital measure
Request the Midwife Obstetric Unit (MOU) admission register and select three health records of three users who have been discharged from the unit in the previous week. Check whether the discharge summaries in the maternity case records have been comprehensively completed. Score 1 if the aspect is included and 0 if not recorded.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. Name and surname of user		
2. Date of birth or Identity number or passport number		
3. Date of delivery		
4. Date of discharge		
5. Type of delivery		
6. Name of the health establishment to which the user was admitted		
7. Examination findings on discharge		
8. Family planning discussed		
9. Feeding options discussed		
10. Medicine and treatment given		
11. Postnatal advice on discharge		
Information regarding the baby:		
12. Gender		
13. Weight		
14. Head circumference in centimetres		
15. Length in centimetres		
16. BCG vaccination given		
17. Polio vaccination given		
18. Health care provider's name and surname		
19. Health care provider's designation		
20. Health care provider's signature		
21. Date signed by health care provider		

Unit 2 User health record 2

Aspects	Score	Comment
1. Name and surname of user		
2. Date of birth or Identity number or passport number		
3. Date of delivery		
4. Date of discharge		
5. Type of delivery		
6. Name of the health establishment to which the user was admitted		
7. Examination findings on discharge		
8. Family planning discussed		
9. Feeding options discussed		
10. Medicine and treatment given		
11. Postnatal advice on discharge		
Information regarding the baby:		
12. Gender		
13. Weight		
14. Head circumference in centimetres		
15. Length in centimetres		
16. BCG vaccination given		
17. Polio vaccination given		
18. Health care provider's name and surname		
19. Health care provider's designation		
20. Health care provider's signature		
21. Date signed by health care provider		

Unit 3 User health record 3

Aspects	Score	Comment
1. Name and surname of user		
2. Date of birth or Identity number or passport number		
3. Date of delivery		
4. Date of discharge		
5. Type of delivery		
6. Name of the health establishment to which the user was admitted		
7. Examination findings on discharge		

8. Family planning discussed		
9. Feeding options discussed		
10. Medicine and treatment given		
11. Postnatal advice on discharge		
Information regarding the baby:		
12. Gender		
13. Weight		
14. Head circumference in centimetres		
15. Length in centimetres		
16. BCG vaccination given		
17. Polio vaccination given		
18. Health care provider's name and surname		
19. Health care provider's designation		
20. Health care provider's signature		
21. Date signed by health care provider		

Sub Domain 5.2.2 7 Clinical management

Standard 5.2.2.1 7(1) The health establishment must establish and maintain clinical management systems, structures and procedures that give effect to national policies and guidelines.

Criterion 5.2.2.1.1 7(2)(a) The health establishment must ensure that clinical policies and guidelines for priority health conditions issued by the national department are available and communicated to health care personnel.

5.2.2.1.1.1 National guidelines on priority health conditions are available.

Assessment type: Document - **Risk rating:** Essential measure

Use the checklist below to check whether a copy of the guidelines is available. Guidelines can be available electronically or via a mobile application (App). Check that the most current guidelines are being used. Score 1 if the guideline is available and 0 if it is not available.

Score	**Comment**

Aspects	**Score**	**Comment**
1. Guidelines for Maternity Care in South Africa (2016) or latest		
2. Clinical Guidelines for Breast Cancer Control and Management (2019) or latest		
3. National Contraceptives clinical guidelines (2019) or latest		
4. National Consolidated guidelines for the management of HIV in adults, adolescents, children and infants and prevention of mother-to-child transmission (2020) or latest		
5. Maternal, Perinatal and Neonatal health policy (2021) or latest		

6. Clinical Guideline for Genetics Services (2021) or latest		
7. National Clinical Guidelines for Safe Conception and Infertility (2019) or latest		

Standard 5.2.2.2 7(2) (b) A health establishment must establish and maintain systems, structures and programmes to manage clinical risk.

Criterion 5.2.2.2.1 7 The health establishment implements process to ensure environmental cleanliness.

5.2.2.2.1.1 The unit is observed to be clean.

Assessment type: Observation - **Risk rating:** Vital measure

Inspector to observe general cleanliness in all areas of the health establishment. Cleanliness could include but not limited to whether the area is free of dirt and dust.

Not applicable: Never

Score	Comment

Criterion 5.2.2.2.2 7 The management of emergency resuscitations must be guided and monitored to improve user outcomes.

5.2.2.2.2.1 The emergency trolley is stocked with the medicines, medical supplies and equipment.

Assessment type: Observation - **Risk rating:** Non-negotiable measure

Use the checklist below to check whether the emergency trolley is stocked with unexpired medicines and the equipment listed below. Check whether the equipment and medicines are available on the emergency trolley (or on other surfaces in the resuscitation room) and also check the expiry dates of medicines and medical supplies. Score 1 if the aspect listed is available, functional and not expired (if applicable) and score 0 if the aspect is not available or functional or expired (if applicable). In the CHC where the units are in close proximity the emergency trolley can be shared by various units. Emergency trolley must be assessed in the unit where it is located.

Score	Comment

Aspects	Score	Comment
Devices to open and protect airway.		
1. Laryngoscope handle- Adult		
2. Laryngoscope handle- Neonatal		
3. Curved blade for laryngoscope (a minimum of two different sizes)		
4. Straight blades for laryngoscope (a minimum of two different sizes)		
5. Endotracheal tubes- neonatal (a minimum of three different sizes)		
6. Endotracheal tubes- adult (a minimum of five different sizes)		
7. Plaster or ties for endotracheal tubes		
8. Lubricating gel		

Equipment for difficult Intubation		
9. Laryngeal mask airway (a minimum of four different sizes that accommodate both adult and neonatal users)		
10. Magill's forceps (adult)		
11. Magill's forceps (infant)		
12. Adult-size introducer		
Devices to deliver oxygen/ventilate users.		
13. Manual resuscitator device or bag and valve mask (adult)		
14. Manual resuscitator device or bag and valve mask (neonatal)		
15. Oxygen masks- re breather 60% (adult)		
Devices to gain intravascular access.		
16. Intravenous administration sets		
17. IV Cannulae (a minimum of three different sizes that accommodate both adult and neonatal users)		
18. Strapping to secure Intravenous cannulae		
Medicine		
19. Emergency medicines according to local protocol are available and have not expired.		
Equipment to diagnose and treat cardiac dysrhythmias.		
20. Automated external defibrillator (AED) or defibrillator with pads, paddles, conductive gel and electrodes. Explanatory note: Score not applicable if the health establishment has been listed as one of the facilities excluded from keeping these items. The health establishment must be listed in the letter signed by relevant authority and communicated to NDOH. Relevant authority refers to provincial department of health, district health authority or municipal authority.		

5.2.2.2.2.2 Medical supplies and equipment for resuscitation is available.

Assessment type: Observation - **Risk rating:** Vital measure

Inspect whether medical supplies and equipment used for resuscitation is available. The items may be available in the trolley or vicinity of the trolley. Score 1 if the aspect listed is available, functional and not expired (if applicable) and score 0 if the aspect is not available, not functional or expired (if applicable). In the CHC where the units are in close proximity the emergency management items can be shared by various units and assessed in the unit where they are located.

Score	**Comment**

Aspects	**Score**	**Comment**
1. Emergency trolley with lockable medicine drawer and accessories		

2. Patient trolley or stretcher which can be adjusted into a fowlers position		
3. Cardiac arrest board		
4. Chlorhexidine or Alcohol swabs		
5. Eye protection		
6. Facemasks		
7. Gloves		
8. Syringes (a minimum of five different sizes)		
9. Catheter tip syringe 50ml		
10. Needles (a minimum of five different sizes that accommodate both adult and neonatal users)		
11. Scissors		
12. Tourniquet		
13. Stethoscope		
14. Oropharyngeal airway (a minimum of four different sizes that accommodate both adult and neonatal users)		
15. Nasogastric tube (a minimum of four different sizes that accommodate both adult and neonatal users)		
16. Suction catheter (a minimum of four different sizes that accommodate both adult and neonatal users)		
17. Suction devices (portable)		
18. Nasal cannula		
19. Spare bulb		
20. Spare batteries for laryngoscope.		

5.2.2.2.2.3 The emergency trolley is checked in accordance with agreed unit practice.

Assessment type: Document - **Risk rating:** Vital measure

Request a documented practice for checking the emergency trolley and verify whether it is checked as documented. Request documented records of checking the emergency trolley from the previous 30 days.

Not applicable: Where the emergency trolley is kept in other unit and shared with MOU.

Score	Comment

Criterion 5.2.2.2.3 7 Communication systems must be available and functional to facilitate adequate user care, and safety of user and health care personnel.

5.2.2.2.3.1 Functional, accessible telephones are available.

Assessment type: Observation - **Risk rating:** Essential measure

A telephone that is in working order must be available, this also includes mobile phones.

Not applicable: Never

Score	Comment

Sub Domain 5.2.3 8 Infection prevention and control programmes

Standard 5.2.3.1 8(1) The health establishment must maintain an environment, which minimises the risk of disease outbreaks, the transmission of infection to users, health care personnel and visitors.

Criterion 5.2.3.1.1 8(2)(a) The health establishment must ensure that there are hand washing facilities in every service area.

5.2.3.1.1.1 Hand washing facilities are available.

Assessment type: Observation - **Risk rating:** Vital measure

Check whether the hand washing facilities and items listed below are available. Select an antenatal section/area, a delivery room/area and a postnatal section/area for review. Score 1 if the aspect is available and 0 if it is not available.

Score	Comment

Unit 1 Antenatal room or area

Aspects	Score	Comment
1. Functional hand wash basin. Explanatory note: The basin should not be blocked, broken, or have cracks.		
2. Taps are functional and not broken. Explanatory Note: Taps must be elbow or non-touch operated in user care areas.		
3. Liquid hand soap.		
4. Wall mounted soap dispenser		
5. Paper towel dispenser with disposable hand paper towels		
6. General waste container. Explanatory note: This could be a wall mounted or a disposable or reusable vessel placed at the point of waste generation for the purpose of receiving waste. It may include but not limited to a bin, bucket, box, etc. The container must be lined with the appropriate colour coded liner.		

Unit 2 Delivery room or area

Aspects	Score	Comment
1. Functional hand wash basin. Explanatory note: The basin should not be blocked, broken, or have cracks.		
2. Taps are functional and not broken. Explanatory Note: Taps must be elbow or non-touch operated in user care areas.		
3. Liquid hand soap.		
4. Wall mounted soap dispenser		
5. Paper towel dispenser with disposable hand paper towels		

6. General waste container. Explanatory note: This could be a wall mounted or a disposable or reusable vessel placed at the point of waste generation for the purpose of receiving waste. It may include but not limited to a bin, bucket, box, etc. The container must be lined with the appropriate colour coded liner.		

Unit 3 Postnatal room or area

Aspects	Score	Comment
1. Functional hand wash basin. Explanatory note: The basin should not be blocked, broken, or have cracks.		
2. Taps are functional and not broken. Explanatory Note: Taps must be elbow or non-touch operated in user care areas.		
3. Liquid hand soap.		
4. Wall mounted soap dispenser		
5. Paper towel dispenser with disposable hand paper towels		
6. General waste container. Explanatory note: This could be a wall mounted or a disposable or reusable vessel placed at the point of waste generation for the purpose of receiving waste. It may include but not limited to a bin, bucket, box, etc. The container must be lined with the appropriate colour coded liner.		

5.2.3.1.1.2 Alcohol based hand rub is available.

Assessment type: Observation - **Risk rating:** Vital measure

Observe whether alcohol-based hand rub is available in the areas listed below. Score 1 if available and 0 if not available.

Score	Comment

Aspects	Score	Comment
1. Ante natal room /area		
2. Delivery room/ area		
3. Postnatal room or area		

5.2.3.1.1.3 Posters on hand hygiene are displayed.

Assessment type: Observation - **Risk rating:** Essential measure

Select three areas and observe whether posters on hand hygiene are displayed. This could be a single hand hygiene poster or individual posters for hand washing or correct use of alcohol-based hand rub. Score 1 if available and 0 if not available.

Score	Comment

Aspects	Score	Comment

1. Ante natal room /area		
2. Delivery room/ area		
3. Postnatal room or area		

Criterion 5.2.3.1.2 8(2)(c) The health establishment must ensure there is clean linen to meet the needs of users.

5.2.3.1.2.1 Clean linen is available in the health establishment.

Assessment type: Observation - **Risk rating:** Essential measure
Check whether clean linen is available as determined by the unit requirements. This can be cloth or disposable linen.
Not applicable: Never

Score	Comment

5.2.3.1.2.2 A wheeled cart or trolley is used to collect dirty, soiled and infectious linen.

Assessment type: Observation - **Risk rating:** Vital measure
Observe if the health establishment has a wheeled cart or trolley for collecting soiled and infectious linen.
Not applicable: Never

Score	Comment

Criterion 5.2.3.1.3 8(2)(d) The health establishment must ensure that health care personnel are protected from acquiring infections through the use of personal protective equipment and prophylactic immunisations.

5.2.3.1.3.1 Personal protective equipment is worn.

Assessment type: Observation - **Risk rating:** Vital measure
Using the checklist below, verify whether protective clothing and equipment is worn. Score 1 if the items are worn 0 if not worn. Score not applicable where at the time of the inspection, personnel are not in a situation in which they are required to wear protective clothing.

Score	Comment

Unit 1 Antenatal room/area

Aspects	Score	Comment
1. Gloves - non-sterile		
2. Gloves - sterile		
3. Disposable gowns or aprons		

4. Face masks		
5. N95 or KN95 or FFP2 respirator or approved equivalent.		
6. Protective face shields or goggles		

Unit 2 Delivery room/area

Aspects	**Score**	**Comment**
1. Gloves - non-sterile		
2. Gloves - sterile		
3. Disposable gowns or aprons		
4. Face masks		
5. N95 or KN95 or FFP2 respirator or approved equivalent.		
6. Protective face shields or goggles		

Unit 3 Postnatal room/area

Aspects	**Score**	**Comment**
1. Gloves - non-sterile		
2. Gloves - sterile		
3. Disposable gowns or aprons		
4. Face masks		
5. N95 or KN95 or FFP2 respirator or approved equivalent.		
6. Protective face shields or goggles		

Sub Domain 5.2.4 9 Waste management

Standard 5.2.4.1 9(1) The health establishment must ensure that waste is handled, stored, and disposed of safely in accordance with the law.

Criterion 5.2.4.1.1 9(2)(a) The health establishment must have appropriate waste containers at the point of waste generation.

5.2.4.1.1.1 Health care waste is managed as required by waste management practices.

Assessment type: Observation - **Risk rating:** Essential measure

Use the checklist below to check whether health care risk waste is managed as required. Score 1 if the aspect is compliant and score 0 if it is not compliant. If disposable boxes for sanitary waste with gel granules in the bottom of the box for treating the waste are used, no bag is required, and the health establishment can score 1.

Score	**Comment**

Unit 1 Staff toilet

Aspects	Score	Comment
1. Sanitary disposal bins with functional lids or healthcare risk waste box with a lid.		
2. Sanitary disposal bins or boxes lined with red plastic bags. Explanatory note: If the disposable boxes used for sanitary waste have gel granules in the bottom of the box to treat the waste, no bag is required, and the health establishment can score 1		
3. Sanitary disposal bins or boxes are clean and not overflowing		
4. Bins available for general waste		
5. Bins for general waste are lined with appropriate coloured bags (Black, beige, white or transparent packaging can be used.)		

Unit 2 User toilet

Aspects	Score	Comment
1. Sanitary disposal bins with a functional lids or healthcare risk waste box with a lid.		
2. Sanitary disposal bins or boxes lined with red plastic bags. Explanatory note: If the disposable boxes used for sanitary waste have gel granules in the bottom of the box to treat the waste, no bag is required, and the health establishment can score 1		
3. Sanitary disposal bins or boxes are clean and not overflowing		
4. Bins available for general waste		
5. Bins for general waste are lined with appropriate coloured bags (Black, beige, white or transparent packaging can be used.)		

Unit 3 Antenatal room/area

Aspects	Score	Comment
1. Health care risk waste disposal bins with functional lids or health care risk waste box		
2. Health care risk waste disposal bins or boxes lined with red colour plastic bags		
3. Health care risk waste disposal bins or boxes contain only health care waste		
4. Health care risk waste disposal bins or boxes are not overflowing		
5. Bins available for general waste		
6. Bins for general waste are lined with appropriate coloured bags (Black, beige, white or transparent packaging can be used.)		

Unit 4 Delivery room/area

Aspects	Score	Comment

1. Health care risk waste disposal bins with functional lids or health care risk waste box		
2. Health care risk waste disposal bins or boxes lined with red colour plastic bags		
3. Health care risk waste disposal bins or boxes contain only health care waste		
4. Health care risk waste disposal bins or boxes are not overflowing		
5. Bins available for general waste		
6. Bins for general waste are lined with appropriate coloured bags (Black, beige, white or transparent packaging can be used.)		

Unit 5 Postnatal room/area

Aspects	**Score**	**Comment**
1. Health care risk waste disposal bins with functional lids or health care risk waste box		
2. Health care risk waste disposal bins or boxes lined with red colour plastic bags		
3. Health care risk waste disposal bins or boxes contain only health care waste		
4. Health care risk waste disposal bins or boxes are not overflowing		
5. Bins available for general waste		
6. Bins for general waste are lined with appropriate coloured bags (Black, beige, white or transparent packaging can be used.)		

5.2.4.1.1.2 There are appropriate containers for disposal of all types of waste.

Assessment type: Observation - **Risk rating:** Vital measure

Check if the waste containers listed below are available. Score 1 if the waste container is available and score 0 if it is not available. Where a particular type of waste is not generated in the unit, score not applicable.

Score	**Comment**

Aspects	**Score**	**Comment**
1. Infectious non-anatomical waste (red)		
2. Sharps (yellow). Explanatory note: Sharps are disposed of in impenetrable, tamperproof containers		
3. General waste (black, beige, white or transparent packaging can be used)		
4. Human anatomical waste (red bucket with tight fitting lid). Explanatory note: This will be applicable where anatomical waste is generated such as but not limited to products of conception and placentas.		

5. Sanitary disposal bins or boxes lined with red plastic bags. Explanatory note: If the disposable boxes used for sanitary waste have gel granules in the bottom of the box to treat the waste, no bag is required, and the health establishment can score 1.		

Criterion 5.2.4.1.2 9(2)(b) The health establishment must implement procedures for the collection, handling, storage and disposal of waste.

5.2.4.1.2.1 Sharps are safely managed and discarded.

Assessment type: Observation - **Risk rating:** Vital measure

Use the checklist below to check whether sharps are safely managed and discarded. Score 1 if compliant, score 0 if not compliant.

Score	Comment

Unit 1 Antenatal area/room

Aspects	Score	Comment
1. Waste is properly segregated. Explanatory note: Only sharps are discarded into the container; no gloves, papers or any other waste is discarded into the container.		
2. Sharps containers are discarded when they reach the limit mark		
3. Sharps containers are placed on a work surface or in wall mounted brackets		
4. Sharps containers have correctly fitting lids		
5. Needles are not recapped before disposal (not applicable for safety needles and syringes)		

Unit 2 Delivery area/room

Aspects	Score	Comment
1. Waste is properly segregated. Explanatory note: Only sharps are discarded into the container; no gloves, papers or any other waste is discarded into the container.		
2. Sharps containers are discarded when they reach the limit mark		
3. Sharps containers are placed on a work surface or in wall mounted brackets		
4. Sharps containers have correctly fitting lids		
5. Needles are not recapped before disposal (not applicable for safety needles and syringes)		

Unit 3 Postnatal area/room

Aspects	Score	Comment
1. Waste is properly segregated. Explanatory note: Only sharps are discarded into the container; no gloves, papers or any other waste is discarded into the container.		
2. Sharps containers are discarded when they reach the limit mark		

3. Sharps containers are placed on a work surface or in wall mounted brackets		
4. Sharps containers have correctly fitting lids		
5. Needles are not recapped before disposal (not applicable for safety needles and syringes)		

5.2.4.1.2.2 The register for human tissue is available and all columns are completed in full.

Assessment type: Document - **Risk rating:** Vital measure
A register must be available for the documentation of human tissue/anatomical waste. Entries made in the register must be complete. The register can be electronic or manual.
Not applicable: Never

Score	Comment

Sub Domain 5.2.5 21 Adverse events
Standard 5.2.5.1 21(1) The health establishment must have a system to monitor and report all adverse events.
Criterion 5.2.5.1.1 21(2)(b) The health establishment must have systems in place to report adverse incidents to a structure in the health establishment or responsible authority that monitors these events.

5.2.5.1.1.1 Health care personnel are aware of the procedure to report adverse events.

Assessment type: Staff interview - **Risk rating:** Vital measure
Interview three health care personnel to establish their awareness on reporting of adverse events. Score 1 if they are able to explain the aspects listed below and 0 if not.

Score	Comment

Unit 1 Healthcare personnel 1

Aspects	Score	Comment
1. Types of adverse events that might happen in the unit (give three examples)		
2. How to report adverse events in the unit?		
3. Feedback processes on reported adverse events. Explanatory notes: This could include but not limited to formal feedback on the progress, outcome and quality improvement plans)		

Unit 2 Healthcare personnel 2

Aspects	Score	Comment
1. Types of adverse events that might happen in the unit (give three examples)		
2. How to report adverse events in the unit?		

3. Feedback processes on reported adverse events. Explanatory notes: This could include but not limited to formal feedback on the progress, outcome and quality improvement plans)		

Unit 3 Healthcare personnel 3

Aspects	Score	Comment
1. Types of adverse events that might happen in the unit (give three examples)		
2. How to report adverse events in the unit?		
3. Feedback processes on reported adverse events. Explanatory notes: This could include but not limited to formal feedback on the progress, outcome and quality improvement plans)		

Domain 5.3 CLINICAL SUPPORT SERVICES

Sub Domain 5.3.1 10 Medicines and medical supplies

Standard 5.3.1.1 10(1) The health establishment must comply with the provisions of the Pharmacy Act, 1974 and the Medicines and Related Substances Act, 1965.

Criterion 5.3.1.1.1 10(2)(a) The health establishment must implement and maintain a stock control system for medicine and medical supplies.

5.3.1.1.1.1 The entries in the schedule 5 and/or 6 drug register are complete and correct.

Assessment type: Document - **Risk rating:** Vital measure

All columns in the registers must be completed comprehensively. Any omitted information noted during the review of the register will receive a non-compliant score. The inspector must confirm that all sections of the register have been completed correctly.

Not applicable: Where schedule 5 and/or 6 medicines are not held in the unit.

Score	Comment

5.3.1.1.1.2 The schedule 5 and 6 medicines in stock correspond with the balance recorded in the drug register.

Assessment type: Document - **Risk rating:** Vital measure

Select three medicines from the schedule 5 and 6 medicine cupboard and verify whether the quantity available corresponds with the balance recorded in the register. Score 1 if there is correspondence 0 if not. Score not applicable where schedule 5 and 6 medicines are not held in the ward.

Score	Comment

Aspects	Score	Comment
1. Medicine 1		
2. Medicine 2		
3. Medicine 3		

Sub Domain 5.3.2 13 Medical equipment

Standard 5.3.2.1 13(1) Health establishments must ensure that the medical equipment is available and functional in compliance with the law.

Criterion 5.3.2.1.1 13(2)(b) The health establishment must ensure that equipment is in accordance with the essential equipment list in all clinical service areas.

5.3.2.1.1.1 Essential equipment is available and functional.

Assessment type: Observation - **Risk rating:** Vital measure

Use the checklist below to check whether essential equipment is available and functional. Check the areas listed below and assess if the listed equipment is available and functional. Score 1 if the item is available and functional and 0 if it is not available or not functional.

Score	Comment

Unit 1 Antenatal room or area

Aspects	Score	Comment
1. Stethoscope		
2. Fetoscope		
3. Non-invasive Blood pressure machine, wall-mounted or portable		
4. Adult, small and large cuffs (for Blood pressure machine)		
5. Diagnostic sets, including ophthalmic pieces, wall-mounted or portable		
6. Tape measure		
7. Clinical thermometers		
8. Ceiling-mounted or mobile examination lamp		
9. Adult clinical scale		
10. Blood glucometer		
11. HB meter		
12. Height measure		
13. Urine specimen jars		
14. Doppler foetal monitor		

Unit 2 Delivery room or area

Aspects	Score	Comment
1. Stethoscope		

2. Fetoscope		
3. Non-invasive blood pressure machine, wall-mounted or portable		
4. Adult, small and large cuffs (for blood pressure machine)		
5. Diagnostic sets, including ophthalmic pieces, wall-mounted or portable		
6. Tape measure		
7. Clinical thermometers		
8. Ceiling-mounted or mobile examination lamp		
9. Baby scale		
10. Bassinet with trolley and mattress		
11. Blood glucometer		
12. HB meter		
13. Urine specimen jars		
14. Doppler foetal monitor.		
15. Incubator		
16. Infant warmer		
17. Suction unit, mobile, electrical, 2 x 2lL bottle		
18. Rescue scissors		
19. Autoclave, stand-alone, mobile, approx. 100L. (This could be stored in any area of the health establishment)		
20. Instruments washing tray with lid 183mm x 140 x 17 mm (This could be located in any area of the health establishment)		
21. Freezer for storing products of conception. Explanatory note: (This could be located anywhere in the health establishment)		

Unit 3 Postnatal room or area

Aspects	**Score**	**Comment**
1. Stethoscope		
2. Non-invasive blood pressure machine, wall-mounted or portable		
3. Adult, small and large cuffs (for blood pressure machine)		
4. Diagnostic sets, including ophthalmic pieces, wall-mounted or portable		
5. Tape measure		
6. Clinical thermometers		

7. Ceiling-mounted or mobile examination lamp		
8. Adult scale		
9. Baby scale		
10. Bassinet with trolley and mattress		
11. Blood glucometer		
12. HB meter		
13. Height measure		
14. Urine specimen jars		
15. Incubator		
16. Infant warmer		
17. Suction unit, mobile, electrical, 2 x 2lL bottle		

5.3.2.1.1.2 Sterile obstetric delivery packs are available.

Assessment type: Observation - **Risk rating:** Vital measure

Use the checklist below to check whether at least three sterile delivery packs are available. Score 1 if the packs are available and not expired and score 0 if it is not available or expired. Sterile packs must be labelled with the contents of the pack. If the pack is not labelled, score 0.

Score	Comment

Unit 1 Delivery pack 1

Aspects	Score	Comment
Included in the pack		
1. Stitch scissor - 1		
2. Episiotomy scissor - 1		
3. Cord scissor - 1		
4. Dissecting forceps non-toothed (plain) - 1		
5. Dissecting forceps toothed - 1		
6. Artery forceps, straight, long - 2		
7. Needle holder - 1		
8. Small bowl - 2		
9. Kidney dishes OR receivers (big) - 2		

Extras - not part of the pack but they must be sterile		
10. Basin - 1		
11. Stainless-steel round bowl, large - 1		
12. Green towels - 4		
13. Linen or disposable gowns - 2		
14. Gauze swabs - 5		
15. Vaginal tampons - 1		
16. Sanitary towels - 2		
17. Round cotton wool balls- 1 pack		
18. Umbilical cord clamps - 2		

Unit 2 Delivery pack 2

Aspects	**Score**	**Comment**
Included in the pack		
1. Stitch scissor - 1		
2. Episiotomy scissor - 1		
3. Cord scissor - 1		
4. Dissecting forceps non-toothed (plain) - 1		
5. Dissecting forceps toothed - 1		
6. Artery forceps, straight, long - 2		
7. Needle holder - 1		
8. Small bowl - 2		
9. Kidney dishes OR receivers (big) - 2		
Extras - not part of the pack but they must be sterile		
10. Basin - 1		
11. Stainless-steel round bowl, large - 1		
12. Green towels - 4		
13. Linen or disposable gowns - 2		
14. Gauze swabs - 5		
15. Vaginal tampons - 1		

16. Sanitary towels - 2		
17. Round cotton wool balls- 1 pack		
18. Umbilical cord clamps - 2		

Unit 3 Delivery pack 3

Aspects	**Score**	**Comment**
Included in the pack		
1. Stitch scissor - 1		
2. Episiotomy scissor - 1		
3. Cord scissor - 1		
4. Dissecting forceps non-toothed (plain) - 1		
5. Dissecting forceps toothed - 1		
6. Artery forceps, straight, long - 2		
7. Needle holder - 1		
8. Small bowl - 2		
9. Kidney dishes OR receivers (big) - 2		
Extras - not part of the pack but they must be sterile		
10. Basin - 1		
11. Stainless-steel round bowl, large - 1		
12. Green towels - 4		
13. Linen or disposable gowns - 2		
14. Gauze swabs - 5		
15. Vaginal tampons - 1		
16. Sanitary towels - 2		
17. Round cotton wool balls- 1 pack		
18. Umbilical cord clamps - 2		

Domain 5.5 FACILITIES AND INFRASTRUCTURE

Sub Domain 5.5.1 14 Management of buildings and grounds

Standard 5.5.1.1 14(1) The health establishment and their grounds must meet the requirements of the building regulations.

Criterion 5.5.1.1.1 14(2)(c) The health establishment must as appropriate for the type of buildings and grounds of the establishment ensure emergency exit and entrance points are provided in all service areas and kept clear at all times.

5.5.1.1.1.1 All emergency exits are kept free of obstacles.

Assessment type: Observation - **Risk rating:** Vital measure
An emergency exit in a structure is a special exit for emergencies such as fire. The combined use of regular and special exits allows for faster evacuation, while it also provides an alternative if the route to the regular exit is blocked by fire, etc. Check that all emergency exits are not obstructed by items including but not limited to chairs, beds, equipment or boxes.
Not applicable: Never

Score	Comment

Criterion 5.5.1.1.2 14(2)(d) The health establishment must as appropriate for the type of buildings and grounds of the establishment have ventilation systems that maintain the inflow of fresh air, temperature, humidity and purity of the air within specified limits set for different service areas such as theatres, kitchen and isolation units.

5.5.1.1.2.1 Clinical service areas have natural ventilation or functional mechanical ventilation.

Assessment type: Observation - **Risk rating:** Vital measure
The National Building Regulations stipulate that satisfactory ventilation is only provided by forcing outdoor air into a space mechanically or passively through either ducting or apertures open to the outside such as windows or ventilation grilles. Check if the areas listed below have passive ventilation (windows, doors that can be opened and ventilation grilles) or functional mechanical ventilation (i.e., ducting system). Score 1 if the aspect is compliant and 0 if it is not compliant.

Score	Comment

Aspects	Score	Comment
1. Antenatal room or area		
2. Delivery room or area		
3. Postnatal room or area		

Sub Domain 5.5.2 15 Engineering services
Standard 5.5.2.1 15(1) The health establishment must ensure that engineering services are in place.

Criterion 5.5.2.1.1 15(2) The health establishment must have 24-hour electrical power, lighting, medical gas, water supply and sewerage disposal system.

5.5.2.1.1.1 An oxygen cylinder with pressure gauge is available in the unit.

Assessment type: Observation - **Risk rating:** Non-negotiable measure
An oxygen cylinder fitted with a regulator indicating cylinder pressure and adjustable flow rate must be available.
Not applicable: Never

Score	Comment

5.5.2.1.1.2 The oxygen available in the cylinder is above the minimum level.

Assessment type: Observation - **Risk rating:** Non-negotiable measure
Oxygen levels must not be below the minimum level indicated in the oxygen cylinder gauge.

Not applicable: Never

Score	Comment

5.5.2.1.1.3 Portable suction is available in the unit.

Assessment type: Observation - **Risk rating:** Vital measure
Verify whether portable suction is available and functional in the unit.
Not applicable: Never

Score	Comment

Official Sign-Off

The National Health Act, 2003 (Act No. 61 of 2003) provides for quality requirements and standards in respect of health services provided by health establishments to the public. The main objective is to promote and protect the health and safety of the users of health services and contribute to improved outcomes and improved population health.
To achieve this mandate standardised inspection tools aligned to Norms and Standards Regulations applicable to different categories of health establishments promulgated by the Minister of Health in 2018 have been developed for Community Health Centres (CHC).

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It is hereby certified that the Regulatory CHC Inspection tools version 1.3 was updated by the Office of Health Standards Compliance.

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