|  |  |  |
| --- | --- | --- |
| Name of the Health Facility: |  | |
| Address: |  | |
| Telephone Number: |  | |
| Name of Responsible Person for Infection Control in this Facility: |  | |
| Services provided in this facility  \* Please tick with √ | Integrated TB-HIV Services | TB Services |
| VCT/ART Services | GOPD |
| In-patient Services |  |

WHO Facility Assessment Checklist

|  |  |  |  |
| --- | --- | --- | --- |
| Managerial | Yes | No | Issues to be Assessed and Guide for Comments |
| 1. Is there an IC team or responsible person in place? |  |  | * At which level? * Composition of the team?   Comments: |
| 2. Is there a Facility IC plan in place? |  |  | Provide copy of the plan, policies and standard procedures and/or describe.   * Is the plan part of the facility plan? * Is the plan properly budgeted? * Is budget available for TB-IC? * Does IC plan include staff training on IC? * How many staff members have been trained in IC last year? * Is there continuous professional education in IC? * Is there coordination between TB and HIV departments? ART, VCT, CPT, IPT available? * How are planned IC activities monitored and evaluated?   Comments: |
| 3. Has an IC assessment been done? |  |  | * When was the last IC check or facility IC risk assessment done? * Is there a plan (renovation and/or re-location) to optimize implementation of IC controls at the facility? * Have any improvements been completed within the last year?   Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| 4. Is ‘’on-site’’ surveillance on TB disease among workers and facility assessment being conducted (including monitoring and evaluation of IC) |  |  | * ‘’on-site’’ surveillance systematically / regularly performed? * Who is responsible for IC surveillance? * Are data / reports available? * Give examples of indicators?   Comments: |
| 5. Is health education on IC ensured for HCWs, patients, and visitors? |  |  | * How is it performed? * Any evidence of activity? * Are materials available for IEC * Provide examples of materials.   Comments: |
| 6. Does the facility participate in operational research (OR)? |  |  | * Are there any OR activities on IC? * How is it organized?   Comments: |

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| --- | --- | --- | --- |
| Administrative | Yes | No | Issues to be Assessed |
| 7. Which of the following recommended controls are practiced?   * Triage, * Separation, * Cough etiquette, * Expedient service delivery (prompt services for ‘’coughers’’) |  |  | * Is there systematic screening of all patients for cough? * Are patients with cough separated early from other patients? * Are suspected or diagnosed TB patients separated from suspected or diagnosed HIV patients. * Is there a system established to prioritize smear positive cases such as creating an ‘’express lane’’ to minimize the stay of these patients. * Is the flow of TB suspects / patients in the facility a risk for transmission? * Is there IEC regarding cough etiquette on site? How is it conducted? * What is the average turn-around time for lab investigations?   Comments: |
| 8. Package of prevention for HCWs, including HIV prevention, ART, and Isoniazid preventive therapy for HIV-positive health workers |  |  | * Periodic and or symptomatic TB screening of staff? * If periodic, how often? * HIV testing offered to HCWs? * If necessary, where is (preventive) treatment offered? * Can HIV + staff opt out from work in a high risk area?   Comments: |

|  |  |  |  |
| --- | --- | --- | --- |
| Environmental | Yes | No | Issue to be assessed: |
| 1. Natural and/or mechanical ventilation in place, especially in waiting areas, examination room, sputum collection room and patient wards |  |  | * What ventilation is in place? * Provide sketch of windows, doors, fans and cross ventilation with measurements * State of moving parts of windows? * Check air flow (with smoke tube, vaneometer) * Calculate ACH * Maintenance of fans? Log complete? * What is the average waiting time?   Comments: |
| 2. Outdoor waiting areas or open space |  |  | * Are outdoor waiting areas large enough to seat patients without crowding. * Use low walls that facilitate movement of fresh air. * The roof of the structure should have sufficient overhang to protect occupants from sun and rain.   Comments: |
| 3. UVGI |  |  | * Sketch if available. * Functioning? Check with UVC meter * Last maintenance check? Log complete? * When were the lamps last replaced?   Comments: |

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| --- | --- | --- | --- |
| Personal Protection | Yes | No | Issue to be assessed: |
| 1. Respirators available for staff |  |  | Which respirator model is used? |
| 2. Fit testing and/or fit check for respirators |  |  | * Where is it performed? * How is it organized? * Frequency of fit test   Comments: |
| 3. Surgical masks/handkerchiefs for coughing patients |  |  | * Where is it performed? * How is it organized?   Comments: |
| 4. Staff   * Annual Examinations * Continuing Education |  |  | How is this done?  Comments: |

Specific activities of the assessment:

Make a flowchart of the patient flow through the facility.

Visit the OPD and TB wards and calculate the ACH at various sites.

Sketch of the facility: Include main room, anteroom, hallway, UV lights, other controls, windows, doors, etc.

Summary of the Assessment Visit:

|  |  |
| --- | --- |
| Strengths | Weaknesses |
| -  -  -  - | -  -  -  - |
| Problems Identified | |
| List only comments that would realistically be addressed as priorities in the following year  -  -  -  - | |

Prioritization Table for IC Assessment:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Priority  High/Medium/Low | Description | How to implement?  Who is responsible? | When? | Budget | Comment |
| Managerial Activities | | | | | | |
| 1 |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |
| Administrative Control | | | | | | |
| 1 |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |
| Environmental Control | | | | | | |
| 1 |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |
| Personal Protective Equipment | | | | | |  |
| 1 |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |
| Date of Assessment: | | | | | | |
| Date of Next Assessment: | | | | | | |