Obstetric and Neonatal Inspection Checklist- Final

Name of the Facility: _____

Date of Inspection:_____/_____/_____

Ref.	Description	Yes	No	N/A	Remarks
	STANDARD ONE: HEALTH FACILITY DESIGN REQUIREMENTS				
1	OBSTETRIC UNIT DESIGN				
1.1.	The obstetrical unit shall be located and designed to prohibit non-related traffic through the unit.				
1.2.	Labor Deliver Recovery (LDR) rooms may be located in a separate LDR suite, in close proximity to the caesarean delivery suite.				
1.3.	Antenatal (antepartum) rooms shall be single-patient rooms, and should be at least 3.65 meters wide by 3.96 meters deep exclusive toilet rooms, closets, lockers, wardrobes, alcoves, or vestibules.				
1.4.	In shared inpatient rooms, the enclosed area for each bed shall be provided with curtains to ensure patient privacy. Such area should be at least 7.5 square meters.				
1.5.	Each LDR and Labor Deliver Recovery Postpartum (LDRP) room shall be for single occupancy and shall have a minimum clear floor area of 31.57 square meters with a minimum clear dimension of 3.96 square meters.				
1.6.	The infant stabilization and resuscitation space shall have designated area in the LDR or LDRP room that is distinct from the mother's area. This should include an infant stabilization and resuscitation space with a minimum clear floor area of at least 3.7 square meters. Space consideration shall be made whenever a crib and reclining chair are provided in the LDR and LDRP room.				

1.8.	The LDR or LDRP room should be equipped with the following:				
1.8.1.	Delivery bed				
1.8.2.	Birthing light				
1.8.3.	Medical gas and vacuum system accessible to the mother's delivery area and infant resuscitation				
1.8.4.	Nurse call system				
1.8.5.	Emergency call system				
1.8.6.	Telephone or communication system				
1.8.7.	Sixteen (16) Electric receptacles (8 convenient to head of bed with one on each wall and four (4) convenient to each bassinet with one on each wall).				
1.8.8.	Hand Hygiene				
1.9.	A minimum of one caesarean delivery room shall be provided for every obstetrical unit unless direct access for caesarean delivery procedures is provided in surgical operation room. The caesarean delivery room shall have a minimum clear floor area of 40.85 square meters with a minimum clear dimension of 4.88 meters. Infant resuscitation space shall be provided in the caesarean delivery room. If provided separate, the infant resuscitation space should be immediately accessible to the caesarean delivery room and shall have a minimum clear floor area of 13.94 square meters.				
1.10.	The scrub facility shall be located adjacent to caesarean delivery room.				
1.11.	Separate staff changing area for males and females.				
1.12.	A minimum of two recovery spaces shall be provided for caesarean delivery suits, with a minimum clear floor area of 7.43 square meters shall be provided for each bed.				
1.13.	Patient rooms in the postnatal unit shall have the minimum clear floor area of 13.94 square meters in				

	single-bed rooms, and 11.52 square meters per bed in multiple-bed rooms postnatal rooms.				
1.14.	Newborn nursery room (if provided) should contain no more than sixteen (16) infant stations.				
1.15.	Postnatal wards shall have a dedicated area for neonatal resuscitation facilities.				
1.16.	The newborn nursery should have minimum clear floor area of 2.23 square meters per bassinet, exclusive of auxiliary work area.				
1.17.	Support areas for obstetric unit should consist of the following:				
1.17.1.	Nurse station with dedicated documentation area.				
1.17.2.	Secured medication safety zone.				
1.17.3.	Nourishment area.				
1.17.4.	Clean workroom or clean supply room.				
1.17.5.	Soiled workroom or soiled holding room.				
1.17.6.	Equipment and supply storage.				
1.17.7.	Environmental services room.				
1.17.8.	Hand washing /scrub station.				
1.17.9.	Examination / treatment and /or multipurpose diagnostic testing room (if required).				
1.17.10.	Clean linen cabinet				
1.17.11.	Staff changing room / staff resting room				
2	**NEONATAL UNIT DESIGN**				
2.1.	The NICU shall be designed as part of an overall safety program to protect the physical security of infants, parents, and staff and to minimize the risk of infant abduction.				
2.2.	All entries to the NICU shall be controlled. The family entrance and reception area shall be clearly identified.				
2.3.	The reception area shall permit visual observation and				

	contact with all traffic entering the unit.				
2.4.	There should be efficient access to the unit from the labor and delivery area and emergency department.				
2.5.	The NICU should be located on the same floor as of Labor Suit and Operation Theatre.				
2.6.	Adequate ventilation and air exchange, with at least six (6) air changes per hour as per American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE) requirement, shall be maintained in NICU. NICU should be kept at positive pressure relative to the adjacent areas. The area temperature should be maintained at 21°C - 24°C and relative humidity 30 % to 60% and should be adjustable. High efficiency filters should be installed in the air handling system, with adequate facilities provided for maintenance, without introducing contamination to the delivery system or the area served.				
2.7.	NICU Nursery Rooms and Areas				
2.7.1.	In multiple-bed rooms, including ones with cubicles or fixed cubicle partitions, each patient care space shall contain a minimum clear floor area of 11.15 square meters per infant care bed excluding sinks and aisles.				
2.7.2.	Rooms intended for the use of a single infant shall contain a minimum clear floor area of 13.94 square meters excluding sinks and aisles.				
2.7.3.	In multiple bedrooms, there shall be an aisle adjacent to each infant care space with a minimum width of 1.22 meters.				
2.7.4.	When single-bed rooms or fixed cubicle partitions are used in the design, there shall be an adjacent aisle with a minimum clear width of 2.44 meters to permit the passage of equipment and personnel.				

2.7.5.	In multiple-bed rooms, a minimum clearance of 2.44 meters shall be provided between infant care beds.				
2.7.7.	A source of daylight shall be visible from infant care areas, either from each infant area itself or from an adjacent area. When a window(s) is provided, the following requirements shall be met:				
b.	All daylight sources shall be equipped with shading devices.				
2.7.8.	Each patient care space shall be designed to allow visual privacy for the infant and family.				
2.7.9.	In multiple-bedroom, every bed position shall be within 6.10 meters of a hands-free hand-washing station.				
2.7.10.	Where an individual room concept is used, a hands-free hand-washing station shall be provided in each infant care room.				
2.7.11.	Each NICU bed should have the following:				
a.	Sixteen (16) electrical receptacles convenient to head of bed with one on each wall.				
b.	Three (3) station outlets for oxygen per infant care bed.				
c.	Three (3) station outlets for vacuum (suction) per infant care bed.				
d.	Three (3) station outlets for medical air systems per infant care bed.				
2.7.12.	NICU rooms providing all levels of care should have lights with a dimmer control.				
2.7.13.	Provision of suitable number of counters/desks for documentation or computers in NICU unit for Level II and above, at a ratio of 1:2 (one station/desk per 2 NICU beds) is recommended.				
2.8.	Special Patient Care Rooms				
2.8.1.	An Airborne infection isolation (AII) room shall be required with the following requirements:				

b.	AII rooms in the neonatal unit shall comply with the requirements of AII room mentioned in the DHA Hospital Regulation except the requirements for air handling, separate toilet, bathtub, or shower.				
c.	AII rooms in the neonatal unit shall have a minimum clear floor area of 11.15 square meters.				
d.	Anteroom with hand washing station.				
2.9.	Support areas for the neonatal unit				
2.9.1.	Nurse station with documentation area				
2.9.3.	Medications safety zone				
2.9.4.	Clean workroom or clean supply				
2.9.5.	Soiled workroom or soiled holding				
2.9.6.	Emergency equipment storage				
2.9.7.	Environmental services room				
2.9.9.	Infant feeding preparation facilities				
a.	Location: space for preparation and storage of formula and additives to human milk and formula shall be provided in the unit or other location away from the bedside.				
b.	The following functional spaces shall be provided when infant feedings are prepared onsite:				
i.	Anteroom area				
ii.	Preparation area				
iii.	Storage space				
iv.	Clean up area				
e.	Surfaces in infant feeding preparation areas shall be non-absorbent, smooth and easily cleaned.				
f.	Wall construction, finish, and trim, including joints between the walls and the floors, shall be free of insect and rodent harbouring spaces.				
g.	Walls shall be non-absorbent, smooth, easily cleaned and				

	light in colour.				
2.9.10.	Lactation support space: the space shall be provided for lactation support and consultation immediately accessible to the NICU.				
a.	A hand washing station and counter shall be provided in, next to, or directly accessible to the lactation support space.				
b.	Lactation support space shall have comfortable chairs for providing Kangaroo mother care.				
c.	Provisions shall be made for the following immediately accessible to the NICU:				
i.	Refrigeration and freezing				
ii.	Storage for pumps and attachments and educational materials				
2.9.11.	Waiting room for families and visitors				
2.9.12.	Area for counselling with the parents of newborns with major clinical issues may be provided. This area should have a desktop with a large screen and white board.				
2.9.13.	Support areas for staff which may include staff lounge, storage facilities, changing areas and toilets				
	STANDARD TWO: OBSTETRIC SERVICE REQUIREMENTS				
3	ANTENATAL CARE				
3.13.	To provide antenatal care the facility should have the following equipment:				
3.13.1.	Vital signs Monitor				
3.13.2.	Feotoscope				
3.13.3.	Electrocardiogram (ECG)				
3.13.4.	Cardiotocography (CTG) monitor				
3.13.5.	Ultrasonography				
3.13.6.	Access to laboratory testing.				
3.13.7.	Emergency crash cart with proper supplies and				

	medication.				
4	**OBSTETRIC LEVELS OF CARE**				
4.1.	Level I - Basic care				
4.1.1.	Provide a basic level of care to uncomplicated pregnancies for pregnant women at thirty five (35) weeks of gestation and above.				
4.1.4.	Provide ultrasonography imaging services for maternal and fetal assessment with minimal of the following probes (convex, 4D convex, endo-cavity), and cardiotocography (CTG)				
4.1.5.	Provide clinical laboratory services for on 24/7 basis.				
4.1.7.	Establish formal transfer plans in partnership with a higher-level receiving health facility.				
4.1.10.	The following equipment shall be available in each labor room:				
a.	A labor bed.				
b.	Vital signs monitor and stethoscope				
c.	CTG monitor.				
d.	Access to portable ultrasonography.				
e.	Intravenous solutions and infusion pumps.				
f.	Equipment for inhalation and regional anesthesia.				
g.	Emergency/crash cart with proper supplies and medication.				
h.	Instruments and equipment for normal or operative delivery (including vacuum and forceps).				
i.	Medications for the mother and infant (appendix 5).				
4.1.11.	The hospital should have educational posters and clear pathways and protocols for major obstetric situations such as shoulder dystocia, Post- Partum Haemorrhage (PPH) and ecliptic seizure.				
4.1.13.	Health facilities providing Level I obstetric care shall				

	provide a Level I. neonatal care services to newborn infants.				
4.2.	Level II - Specialty Care				
	Level II obstetric care can provide care to high-risk pregnancies and for pregnant women at thirty two (32) gestational weeks and above, unless an emergency medical condition exists. Health facilities providing Level II obstetric care shall maintain the capabilities of Level I in addition to the below:				
4.2.1.	Capability to perform Computed Tomography (CT) scan and Magnetic Resonance Imaging (MRI).				
4.2.4.	Health facilities providing Level II obstetric care shall maintain level II neonatal care units.				
4.3.	Level III - Subspecialty Care				
	Level III obstetric care can provide care to more complex obstetric and fetal cases as well as pregnant women at less than thirty two (32) gestational weeks. Health facilities providing Level III obstetric care shall maintain the same capabilities of Level II in addition to the below:				
4.3.1.	Provide advanced ultrasonography imaging services for maternal and fetal assessment with minimal of the following probes (convex, 4D convex, endo- cavity, linear, small part linear), including Doppler studies on 24/7 basis.				
4.3.2.	Have medical and surgical Intensive Care Units (ICUs).				
4.3.3.	Provide ventilation and ability to stabilize the patient in labor and delivery until transferred safely to ICU when needed.				
4.3.5.	Health facilities providing Level III obstetric care shall maintain Level III and/or Level IV neonatal care units.				
	STANDARD THREE: NEONATAL SERVICE REQUIREMENTS				
5	NEONATAL LEVELS OF CARE				

5.1.	Level I - Basic care				
5.1.6.	Provide clinical laboratory services, x-ray and ultrasonography on 24/7 basis.				
5.2.	Level II - Specialty Care				
	Level II neonatal care services shall have the same capabilities of level I in addition to the below capabilities:				
5.2.1.	Provide care for stable or moderately ill newborn infants who are:				
a.	Born at more than 32 weeks of gestational age.				
b.	Weighs more than or equal to 1500 g at birth with problems that are expected to resolve rapidly.				
5.2.8.	Hospitals providing level II shall maintain the below requirements, in addition to level I:				
a.	Access to radiology services (CT and MRI) on 24/7 basis.				
i.	Neonatal intensive care incubators				
ii.	Neonatal ventilator				
iii.	Syringe/infusion pumps (0.1 ml/hour)				
iv.	Neonatal resuscitator along with emergency/crash cart including proper supplies and medication.				
v.	Blood gas analyzer				
vi.	Phototherapy units				
vii.	Portable x-rays				
viii.	Portable ultrasound scanning				
ix.	Breast pump machine				
x.	Oxygen analyser/pulse oximeter				
xi.	Umbilical arterial and venous catheter				
xii.	Neonatal monitors to measure heart rate, respiratory rate, blood pressure, transcutaneous or intra-arterial oxygen tension, oxygen saturation and ambient oxygen				
xiii.	Medications for infant				

xiv.	Portable incubator with ventilator.				
5.3.	Level III – Sub specialty intensive care (NICUs)				
	Level III neonatal care services shall have the same capabilities of level II in addition to the below capabilities:				
5.3.1.	Provide care for the infants who are born at less than 32 gestational age, weigh less than 1500gm at birth, or have medical or surgical conditions, regardless of gestational age.				
5.3.2.	Provide a full range of respiratory support (ongoing assisted ventilation for 24 hours or more) that may include conventional and/or high frequency ventilation and inhaled nitric oxide.				
5.3.3.	Provide a full range of physiologic monitoring equipment, laboratory and imaging facilities, nutrition and pharmacy support with paediatric expertise.				
5.3.4.	Provide hypothermia system (total body cooling) and capability to perform cerebral function monitoring.				
5.3.5.	Perform advanced imaging, with interpretation on an urgent basis, including computed tomography, MRI, and ECG.				
5.4.	Level IV services				
5.4.3.	Ensure the availability of, or access to land rotor or fixed-wing transport services for a quick and safe transfer of infants requiring subspecialty intervention. Potential transfer to higher-level facilities or pediatric hospitals, as well as back-transport of recovering infants to lower-level facilities, should be considered as clinically required.				
	STANDARD FOUR: GENERAL SERVICE REQUIREMENTS				
7.1.	As per DHA's Informed consent guidelines, the health facility should identify treatments and procedures that				

	requires obtaining specific informed consent from patients/carers regarding obstetric and neonatal procedures.				
8	**INFECTION CONTROL**				
8.1.3.	The policy shall emphasis on (but not limited to) the following:				
a.	Hand hygiene.				
b.	Appropriate use of Personal Protective Equipment (PPE)				
c.	Proper performance of environmental cleaning and disinfection on a routine and consistent basis to provide for a safe and sanitary environment				
d.	Equipment Reprocessing				
e.	Family, staff and visitors with emphasis on restricting visits if they are unwell with signs and symptoms that are possibly infectious in etiology.				
f.	Readmission from community or transfer from another hospital.				
g.	Transfer In – mothers/babies who are transferred in from other hospitals should be screened for Methicillin resistant staph aureus (MRSA).				
h.	Transfer Out – mothers receiving facilities should be notified about any known infection, colonization or exposure.				
i.	Transfer In –newborns that are transferred in should be screened for the presence of Methicillin-resistant Staphylococcus aureus (MRSA), respiratory viruses using the respiratory multiplex and other Multi-resistant organisms (MROs), if suspected, consider putting the newborn on additional precautions until results are known, dependent on the assessed level of risk (e.g., outbreak in the transferring unit, maternal colonization risk).				

9	**FALL MANAGEMENT**				
9.1.	Health facilities providing obstetric and neonatal care shall develop and implement a policy for falls management. Both women and neonates shall be assessed for risk of falls based on the following events:				
9.1.1.	On admission and transfer to another unit.				
9.1.2.	Following a change of health status.				
9.1.3.	After a fall.				
10	**BLOOD MANAGEMENT**				
10.1.	Health facilities providing obstetric and neonatal care shall develop and implement a policy to ensure safe and appropriate practice and management of sample collection, blood and blood products in line with the local regulations and related federal laws.				
10.3.	Health facilities shall provide the appropriate equipment and supplies necessary for blood management.				
12	**NUTRITIONAL NEEDS**				
12.1.	All health facilities shall develop and implement a policy for nutritional management aimed to optimize nutrition and prevent malnutrition detailing the following, but not limited:				
12.1.1.	The importance of the breastfeeding.				
12.1.2.	Newborn babies who can start breast milk or formula milk by mouth or through nasogastric (NG)/ orogastric (OG) tube.				
12.1.3.	Newborn babies who are very small, sick or cannot coordinate sucking, breathing, and swallowing.				
12.1.4.	The outsourcing of the parenteral nutrition preparation and its administration.				
12.1.5.	The preparation (including the required equipment and preparation area), safe storage and handling of the newborn formula.				

14	**SECURITY**				
14.3.	To minimize the risk of infant abduction all areas including newborn nurseries, intrapartum and postnatal should be controlled and part of hospital safety program.				
15	**TRANSFER**				
15.1.	Transfer of patients with emergency conditions shall be conducted in accordance with written hospital policy and shall adhere to the DHA's requirements.				
15.2.	The policy should include:				
15.2.1.	Transfer criteria				
15.2.2.	Healthcare professionals who should be involved in the communication,				
15.2.3.	Appropriate responses where face-to-face briefings are not possible				
15.2.4.	Minimum equipment required to transfer, but not limited to the following:				
a.	Portable suction				
b.	Portable ECG				
c.	Oxygen and breathing equipment				