**CHECKLIST FOR FACILITY CERTIFICATION: CATEGORY A**

ASSESSMENT TOOL FOR FACILITY CERTIFICATION

CATEGORY A: NEWBORN HEARING SCREENING CENTER

1. **FACILITY INFORMATION**

|  |  |
| --- | --- |
| Name of Facility |  |
| Complete Address |  |
|  | No. & Street Barangay |
|  |  |
|  | City / Municipality Province Region |
| Contact Number of Facility  (if any) |  |
| E-mail Address of Facility  (if any) |  |
| Name of Owner |  |
| Name of Facility Manager |  |
| Cellphone of Manager |  |
| Email of Manager |  |
| NHSRC Facility Code (if renewal) |  |
| Classification According to |  |
| Ownership: | [ ] Government [ ] Private |
| Institutional Character: | [ ] Free-standing [ ] Institution-Based |

1. **TECHNICAL REQUIREMENTS**

Instruction to the Applicant: Please prepare all the necessary documents enumerated below.

Instruction to the Inspector: In the appropriate box, place a check mark (✓) if the facility is compliant or X mark (X) if it is not compliant.

|  |  |  |
| --- | --- | --- |
| **STANDARDS AND REQUIREMENTS** | **COMPLIANT** | **REMARKS** |
| 1. **PERSONNEL**   A Category A Facility shall be managed by either a physician or a Clinical Audiologist. Screener/s must be at least 19 years of age, High-school graduate and computer literate. Both manager and screener/s must comply with the minimum requirements set by the NHSRC. | | |
| 1. Manager | | |
| 1. Diploma in Masters in Clinical Audiology for Clinical Audiologists   OR Valid PRC ID for Physicians |  |  |
| 1. A valid certificate of Category A Newborn Hearing Screening Personnel Certifying Course |  |  |
| 1. Facility ID/ Memorandum of Agreement/ Contract of Appointment or Designation (for employees) |  |  |
| 2. Screener (1) | | |
| 1. Valid ID (PRC license for healthcare professionals/ company ID) |  |  |
| 1. A valid certificate of Category A Newborn Hearing Screening Personnel Certifying Course |  |  |
| Screener (2) | | |
| 1. Valid ID (PRC license for healthcare professionals/ company ID) |  |  |
| 1. A valid certificate of Category A Newborn Hearing Screening Personnel Certifying Course |  |  |
| Screener (3) |  |  |
| 1. Valid ID (PRC license for healthcare professionals/ company ID) |  |  |
| 1. A valid certificate of Category A Newborn Hearing Screening Personnel Certifying Course |  |  |
| **B. EQUIPMENT** | | |
| **Hearing Screening Equipment 1**  Type: [ ] Otoacoustic Emission (OAE)  [ ] Automated Auditory Brainstem Response (AABR) | | |
| 1. Brand / Model: |  |  |
| 1. Serial Number: |  |  |
| 1. Annual calibration certificate |  |  |
| **Hearing Screening Equipment 2**  Type: [ ] Otoacoustic Emission (OAE)  [ ] Automated Auditory Brainstem Response (AABR) | | |
| 1. Brand / Model: |  |  |
| 1. Serial Number: |  |  |
| 1. Annual calibration certificate |  |  |
| **C. PHYSICAL FACILITY**  Every hearing screening facility shall have a physical facility with adequate areas in order to safely, effectively and efficiently provide hearing screening services to the newborns. | | |
| 1. Sufficient space for 1 chair or bassinet and a table enough to carry hearing screening equipment, laptop/desktop and printer |  |  |
| 1. Ambient noise should not be more than 50 dBA |  |  |
| **D. OPERATIONS** | | |
| 1. Refusal Form |  |  |
| 1. Educational material / brochure |  |  |
| 1. Records of newborns screened |  |  |
| 1. Monthly report submitted to NHSRC |  |  |

**III. DEMONSTRATION**

Instruction to the applicant: The following item should be demonstrated in the video recording.

Instruction to the Inspector: In the appropriate box, place a check mark (✓) if the facility is compliant or X mark (X) if it is not compliant.

|  |  |  |
| --- | --- | --- |
| ITEM | Place a check mark (✓) if the facility is compliant or X mark (X) if it is not compliant . | EVALUATOR’S COMMENT (IF NON-COMPLIANT)  (REASON FOR NOT EARNING SCORE) |
| **INTRODUCTION**   1. Name 2. Position 3. Name of facility   **Camera View: Face the camera, remove facemask and introduce yourself and the facility.** |  |  |
| **ROOM MEASUREMENT** | | |
| 1. **OAE/ AABR Room-**   Sufficient space for 1 chair or bassinet and a table enough to carry hearing screening equipment, laptop/desktop and printer.  **Camera View: Show actual room with complete equipment.** |  |  |
| **AMBIENT NOISE** | | |
| 1. Should not be more than 50 dBA for OAE/AABR   **Camera View: Show actual sound level meter while measuring the ambient noise of the room.** |  |  |
| **DEVICE CHECK** | | |
| **OAE/ AABR** machine check if it is in good working condition.  **Camera View: Show actual parameters in a clear view and test a sample patient to check if the machine is working properly.** |  |  |
| **RESULT TEMPLATE:**   * OAE or AABR Screening following the recommended format in the MOP.   **Submit the following in PDF forms.** |  |  |
| **OTHER REQUIREMENTS:**  PPE, cotton, alcohol  **Camera View: Show actual materials.** |  |  |
| **MONITORING AND VALIDATION OF INFORMATION** | | |
| * I hereby confirm that the information provided by me is true and correct. By signing below I acknowledge that the inspectors assigned to our facility can check and verify the information I have given.   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed Name and Signature | | |

**Inspected by:**

|  |  |  |
| --- | --- | --- |
| Printed Name | Signature | Position / Designation / Office |
|  |  |  |
|  |  |  |
|  |  |  |

**Received by:**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position/Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_