**CHECKLIST FOR FACILITY CERTIFICATION: CATEGORY B**

 ASSESSMENT TOOL FOR FACILITY CERTIFICATION

CATEGORY B: 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 B Facility shall be managed by a Clinical Audiologist or Physician however ABR and ASSR results should be interpreted by a Clinical Audiologist or PANORS with ABR Reader Certificate.
* Confirmatory test procedure should always be under the supervision of the Clinical Audiologist/ PANORS with ABR Reader Certificate.
* Category A Screener/s must be at least 19 years of age, High-school graduate and computer literate.
* All personnel under Category B 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 Newborn Hearing Screening Personnel Certifying Course
 |  |  |
| 1. Company ID or Contract of Appointment/ Memorandum of Agreement as Clinical Audiologist/ Manager (for managing more than 1 facility)
 |  |  |
| **2. Audiologist and/or ENT (optional; other than manager)** |
| 1. Masters in Clinical Audiology Diploma OR Valid PRC ID and ABR Reader Certificate
 |  |  |
| 1. Orientation and updates of Category A Newborn Hearing Screening (RA9709)
 |  |  |
| 1. Facility ID/ Memorandum of Agreement/ Contract of Appointment or Designation (for employees)
 |  |  |
|   **3. 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
 |  |  |
| **4. ABR Technician** |
| 1. Valid ID (PRC license for healthcare professionals)
 |  |  |
| 1. Orientation and updates of Category A Newborn Hearing Screening (RA9709)
 |  |  |
| 1. Certificate of training (equipment: ABR, ASSR and Middle Ear Analyzer) by distributor or signed by the in-house Audiologist
 |  |  |
|   **B. EQUIPMENTS** |
| **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
 |  |  |
| **Confirmatory Test Type:** [ ] Auditory Brainstem Response (ABR) [ ] Auditory Steady State Response (ASSR) |
| 1. Brand / Model:
 |  |  |
| 1. Serial Number:
 |  |  |
| 1. Annual calibration certificate
 |  |  |
| 1. For ABR: Specs if capable of frequency specific
 |  |  |
|  **Tympanometer/ Middle Ear Analyzer** |
| 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, diagnostic and behavioral test services to the newborns. |
| 1. **OAE Room-** Sufficient space for 1 chair or bassinet and a table enough to carry hearing screening equipment, laptop/desktop and printer. (Ambient noise should not be more than 50dBA)
2. **ABR, ASSR Room-** Sufficient space for 1 bed and a table enough to carry hearing diagnostic equipment, laptop/desktop, printer and other materials for skin preparation.
 |  |  |
|  **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) |
| INTRODUCTION1. Name
2. Position
3. Name of facility

**Camera View: Face the camera, remove facemask and introduce yourself and the facility.** |  |  |
| **ROOM MEASUREMENT** |
| 1. **OAE Room-**

Sufficient space for 1 chair or bassinet and a table enough to carry hearing screening equipment, laptop/desktop and printer. 1. **ABR, ASSR Room-** Sufficient space for 1 bed and a table enough to carry hearing diagnostic equipment, laptop/desktop, printer and other materials for skin preparation.

**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.** |  |  |
| **ABR TEST PARAMETERS****Camera View: Show actual parameters in a clear view and test a sample patient to check if the machine is working properly.****NOTE: Equipment is capable for Bone ABR and frequency specific testing.** |
| 1. Subject state

*TICK: NATURAL SLEEP or under sedation*1. Transducer

*TICK: Inserts, bone conductor and headphone*1. Electrode montage (as required by machine and/or NHSRC)
2. Channels (1 or 2 channels)
3. Time window: (0-20ms)
4. Number of sweeps : 2,000 sweeps
5. Stimulus (click and toneburst minimum requirement)
6. Stimulus Intensity (at least up to 90dB)
7. Stimulus frequency (frequency specific ABR using toneburst, 500. 1k, 2k, 4k)
8. Stimulus rate:

(23 to 39.1sec)1. Stimulus

Polarity: *TICK*\*condensation\*rarefraction\*alternating1. Grounding
2. Impedance Check

  |  |   |
| **ASSR PARAMETERS****Camera View: Show actual parameters in a clear view and test a sample patient to check if the machine is working properly.** |
| GROUNDING AND IMPEDANCE(test must be perform for the evaluators to see if enough grounding and impendance are met; 5 and below)Artifacts rate must be less than 10% of the recorded response rate. |  |  |
| **Tympanometer/MIddle ear analyzer****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/ AABR
* ABR/ ASSR Diagnostic (Series of results at least 5 most recent)
* Tympanometerand Middle Ear Analyzer

**Submit the following in PDF forms.** |  |  |
| **OTHER REQUIREMENTS:**1. Otoscope
2. Skin preparation solution
3. Gauze, cotton, alcohol
4. PPE

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_