**CHECKLIST FOR FACILITY CERTIFICATION: CATEGORY C**

ASSESSMENT TOOL FOR FACILITY CERTIFICATION

CATEGORY C: NEWBORN HEARING SCREENING CENTER

1. **FACILITY INFORMATION**

|  |  |
| --- | --- |
| Name of Facility |  |
| Complete Address |  |
|  | No. & Street Barangay |
|  |  |
|  | City / Municipality Province Region |
| Contact Number of Facility (must have facility not just manager or screener number) |   |
| 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 C Facility shall be managed by a Clinical Audiologist.
* 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 C must comply with the minimum requirements set by the NHSRC.
* Pediatric Audiometry, Hearing aid evaluation and verification test should always be under the supervision of the Clinical Audiologist.
* Should have a Developmental Pediatrician and Speech Pathologist and/or occupational therapist.
 |
| 1. **Manager**
 |
| 1. Diploma in Masters in Clinical Audiology for Clinical Audiologists
 |   |  |
| 1. A valid certificate of Category A 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 ABR Reader** |
| 1. Diploma in Masters in Clinical Audiology for Clinical Audiologists

OR Valid PRC ID and PANORS ABR Reader Certificate |  |  |
| 1. Orientation and updates of Category A Newborn Hearing Screening (RA9709)
 |  |  |
| 1. Company ID or Contract of Appointment/ Memorandum of Agreement as Clinical Audiologist/ Manager (for managing more than 1 facility)
 |  |  |
|  **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 and/or Audiometrician** |
| 1. Valid ID (PRC license for healthcare professionals/ company ID)
 |  |  |
| 1. A valid certificate of Category A Newborn Hearing Screening Personnel Certifying Course
 |  |  |
| 1. Certificate of training (equipment: ABR and ASSR, Audiometer, Middle Ear Analyzer and Real Ear Measurement) by distributor or signed by the in-house Audiologist
 |  |  |
| **5. Developmental Pediatrician** |
| 1. Valid PRC license
 |  |  |
| 1. Residency certificate
 |  |  |
| 1. Fellowship certificate in Developmental Pediatrics
 |  |  |
| 1. Fellowship certificate from Philippine Pediatric Society
 |  |  |
| 1. Orientation and updates of Category A Newborn Hearing Screening (RA9709)
 |  |  |
| **6. Speech therapist and/or occupational therapist** |
| 1. Diploma
 |  |  |
| 1. Orientation and updates of Category A Newborn Hearing Screening (RA9709)
 |  |  |
|  **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 and Middle Ear Analyzer** |
| 1. Brand / Model:
 |  |  |
| 1. Serial Number:
 |  |  |
| 1. Annual calibration certificate
 |  |  |
| 4. **Diagnostic or Clinical Audiometer** |
| 1. Brand / Model:
 |  |  |
| 1. Serial Number:
 |  |  |
| 1. Annual calibration certificate
 |  |  |
| **5. Real Ear Measurement (REM)** |  |  |
| 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 50 dBA)
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.
3. **For Behavioral Test using Diagnostic Audiometer-** Sound treated booth (</=20dB), toys and reinforcers.
 |  |  |
|  **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.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.
2. **For Behavioral Test using Diagnostic Audiometer-** Sound treated booth (</=20dB), toys and reinforcers.

**Camera View: Show actual room with complete equipment.** |  |  |
| **AMBIENT NOISE** |
| 1. Should not be more than 50 dBA for OAE/AABR
2. Sound treated booth **(</=20dB)??**

**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.** |  |  |
| **Hearing aid fitting equipment** |
| 1. Hearing aid model/brand (Submit a PDF file copy of specs of the hearing aid model)
2. Laptop and/or computer with fitting software
3. Programming cable
4. Hearing aid batteries
5. Ear Impression material kit
6. Hearing aid trial fitting kit
7. Others (such as Hearing aid accessories)

**Camera View: Show actual hearing aid trial and fitting room with equipment (as mentioned above).** |  |  |
| **Real Ear Measurement (REM)** |
| **REM** machine check if it is in good working condition.**Camera View: Show actual parameters in a clear view and test to check if the machine is working properly.** |  |  |
| **RESULT TEMPLATE:*** OAE/ AABR
* ABR/ ASSR Diagnostic ( Series of results at least 5 most recent)
* Tympanometer/ Middle Ear Analyzer
* Play audiometry official result
* Behavioral Test (VROA, etc) official result
* REM official result

**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 |

**As part of monitoring:**

Category C centers are expected to share with NHSRC their regular scheduled meetings (at least quarterly schedule meeting) , to be attended by NHSRC inspector/ representative and /or minutes of the meeting.

Agenda: to check or present census, monitoring of patient, status or progress of program, etc.

**Inspected by:**

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

**Received by:**

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

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

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

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