**WEST AFRICAN COLLEGE OF**

**PHYSICIANS**



**FORMAT FOR**

**ACCREDITATION FOR TRAINING IN AN INSTITUTION**

**UNDER THE COLLEGE’S**

**FELLOWSHIP TRAINING PROGRAMME**

**FACULTY OF COMMUNITY HEALTH**

**WEST AFRICAN COLLEGE OF PHYSICIANS.**

**INSTITUTIONAL ACCREDITATION**

**NAME OF INSTITUTION:…………………………………………………………………………………………….…………….**

**COUNTRY:……………………………………………………………………………………………………………………………….**

**REGION OR STATE OF COUNTRY:……………………………………………………………………………………..………**

**FACULTY:…………………………………………………………………………………………………………………..…………….**

**OTHER INSTITUTIONS WITH WHICH IT HAS ADMINISTRATIVE OVERSIGHT OR LINKAGE FOR TRAINING………………………………………………………………………………………………………………………….…….**

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**…………………………………………………………………………………………………………………………………………….….**

**YEAR……………………………..……… and MONTH………………………….…………………of ACCREDITATION .**

1. **THE INSTITUTION. HIGHLIGHTS FROM PREVIOUS YEAR’S ANNUAL REPORTS.**
2. Number of beds……………………………………………………………………………………….………………..
3. Number of states or districts being served with names……………………………….……………..

………………………………………………………………………………………………………………..…………………

…………………………………………………………………………………………………………….…………………….

……………………………………………………………………………………………………………..……………………

1. Number of clinical departments……………………………………………………………….………………..
2. Number of Allied Health Departments (please tick)

Diagnostic Clinical Laboratories Radiological (Imaging) Department

Pharmacy Physiotherapy

Occupational Health

1. Summary of administrative structure……………………………………………………….………………..

………………………………………………………………………………………………………………………………….

1. List of clinical departments……………………………………………………………………….………………..

…………………………………………………………………………………………………………………………………..

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1. Highlights of main achievements over the previous year…………………………………………..

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**B THE DEPARTMENT (FACULTY).**

1. SUMMARY OF ACTIVITIES IN THE PAST YEAR.

UNITS IN THE DEPARTMENT.

List all the hospital units, Clinics, Health Centres and Field Stations under the Department which are used for training in Community Health. State the Summary of activities in each Facility in the previous year.

|  |  |  |  |
| --- | --- | --- | --- |
| No. | Clinic | Average patients a month | Seen previous year |
| I | Endemic diseases clinic |  |  |
| II | Infant welfare clinic |  |  |
| III | Under fives clinic |  |  |
| IV | School Health clinic |  |  |
| V | Well persons clinic |  |  |
| VI | Ante natal/post natal clinic |  |  |
| VII | Family planning |  |  |
| VIII | School health |  |  |
| IX | Occupational health for industries |  |  |
| X | Special treatment clinics for STIs |  |  |
| XI | General outpatient clinic |  |  |
| XII | Clinic for disabled |  |  |
| XIII | Others. Specify |  |  |
|  |  |  |  |
|  |  |  |  |

1. Name of Main unit (campus) …………………………………………………………………………………………………………………….…………….
2. Location ……………………………………………………………………………………………….…………….

ii) Main function………………………………………………………………………………………………..………

1. Other units (campuses )
2. Location………………………………………………………………………….……………………………………………………………………………………………………………………….…………………………

Main function……………………………………………………….........................................

……………………………………………………………………………………………………………………

Clinics run per week……………………………………………………………………….…………….

1. Location………………………………………………………………………………………………………

………………………………………………………………………………………………………….…………

Main function………………………………………………………………………………………………

…………………………………………………………………………………………………………………….

Clinics run per week…………………………………………………………………………………….

1. Location………………………………………………………………………………………….……………

……………………………………………………………………………………………………..……………..

Main function………………………………………………………………………………..…………….

………………………………………………………………………………………………………..…………..

Clinics run per week…………………………………………………………………………………….

1. Location…………………………………………………………………………………………….…………

……………………………………………………………………………………………………………..……..

Main function……………………………………………………………………………………..……….

…………………………………………………………………………………………………………………....

Clinics run per week…………………………………………………………………………….………

1. Location……………………………………………………………………………………………..………..

………………………………………………………………………………………………………………..…..

Main function………………………………………………………………………………………………

…………………………………………………………………………………………………………………….

Clinic run per week………………………………………………………………………………………

Of the twelve clinics listed,

1. List those not available at all. ……………………………………………………………..

……………………………………………………………………………………………….…………..

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1. Those done with other units in the hospital or other health institutions. ……………………………………………………………………………….……….

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Achievements ……………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………..

…………………………………………………………………………………………………………………………………..

Constraints ………………………………………………………………………………………………………………..

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…………………………………………………………………………………………………………………………………..

1. STAFF LIST TO BE PROVIDED WITH QUALIFICATIONS OF CONSULTANT STAFF.
2. Consultant staff (total)…………………………………………………………………….………..

West African College……………………………………………………………………….………..

National Colleges…………………………………………………………………………….………..

Other Colleges. …………………………………………………………………………………………

Part time consultant staff………………………………………………………………….………

1. Other specialists……………………………………………………………………………..………..
2. Other doctors……………………………………………………………………………..…………….
3. Research staff…………………………………………………………………………….……………..
4. Administrative staff…………………………………………………………………………………..
5. Secretarial staff…………………………………………………………………………………………
6. Total nurses on lying in wards…………………………………………………………………..
7. Total nurses at the outpatients…………………………………………………….…………..
8. Other staff…………………………………………………………………………………….………….

1. OUTPATIENTS DEPARTMENT.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | I. INFRASTUCTURE. | 0 | 1 | 2 | 3 | 4 |
| a. | Physical structure including walls, windows/ doors |  |  |  |  |  |
| b. | Ventilation |  |  |  |  |  |
| c. | Lighting |  |  |  |  |  |
| d. | Waiting area |  |  |  |  |  |
| e. | Sluice |  |  |  |  |  |
| f. | Wash room (staff) |  |  |  |  |  |
| g. | Wash room (clients) |  |  |  |  |  |
| h. | Running water in consulting rooms |  |  |  |  |  |
| i. | Number of consulting rooms |  |  |  |  |  |

Number of items scoring less than 2 ……………………

Percentage score ……………………

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | II. STAFF | 0 | 1 | 2 | 3 | 4 |
| a. | Senior nursing staff |  |  |  |  |  |
| b. | Other nursing staff |  |  |  |  |  |
| c. | Cleaning staff |  |  |  |  |  |
| d. | Other |  |  |  |  |  |

Number of items scoring less than 2 …………………….

Percentage score …………………….

III. SERVICES RENDERED AND PATIENT CLIENT LOAD

Total number of clinics run per week …………………………………………………………………………………….….

Clinics run jointly with other departments………………………………………………………………………………....

…………………………………………………………………………………………………………….………………………………………………………………………………………………………………….…………………………………………………………………………

Grade the functionality of the Clinics. Write NA if Clinic not available

CLINIC GRADING

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | III. SERVICES RENDERED AND PATIENT CLIENT LOAD | 0 | 1 | 2 | 3 | 4 |
| a. | Endemic disease |  |  |  |  |  |
| b. | Infant Welfare |  |  |  |  |  |
| c. | Under fives |  |  |  |  |  |
| d. | School health |  |  |  |  |  |
| e. | Well person’s |  |  |  |  |  |
| f. | Ante/post Natal |  |  |  |  |  |
| g. | Family Planning |  |  |  |  |  |
| h. | Staff welfare |  |  |  |  |  |
| i. | Occupational health for industries |  |  |  |  |  |
| j | Special treatment clinics for STDs |  |  |  |  |  |
| k | General Outpatients |  |  |  |  |  |
| l | Clinics for the disabled |  |  |  |  |  |
| m | Others. Specify |  |  |  |  |  |

Average number of outpatients/clients seen per year; All clinics

New patients/clinic …………………….……………………….. Follow up ……………………………..…………….……..

Number of in-patient beds in the department for all subspecialties………………………………..………….

Number of items scoring less than 2 …………………….

Percentage score …………………….

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | IV. THE CONSULTING ROOMS/AREAS (Equipment) | 0 | 1 | 2 | 3 | 4 |
| a. | Couch |  |  |  |  |  |
| b. | X-ray viewing box |  |  |  |  |  |
| c. | Sphygmomanometer |  |  |  |  |  |
| d. | Thermometer |  |  |  |  |  |
| e. | Spatula |  |  |  |  |  |
| f. | Weighing scales |  |  |  |  |  |
| g. | ……………………………………………………………………………………. |  |  |  |  |  |
| h. | ……………………………………………………………………………………. |  |  |  |  |  |
| i. | ……………………………………………………………………………………. |  |  |  |  |  |

Number of items scoring less than 2 …………………….

Percentage score ………………………

Does the Department have formally designated and institutionally approved PRACTICE AREAS, where consultants, residents and other staff collaborate with the local government to manage, provide and supervise a comprehensive range of primary health services? YES/NO

If yes state the name and location of the practice area.

URBAN: FACILITY…………………………………………………………………………………………………………………………

Local government area………………………………………………………………………………………………..………………

……………………………………………………………………………………………………………………………………….……………

RURAL: FACILITY……………………………………………………………………………………………………………………….….

Local government area…………………………………………………………………………………………………………..……

Add additional sheet if possible.

(Sections V,VI,VII are not applicable)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | VIII. DEPARTMENTAL ADMINISTRATION | 0 | 1 | 2 | 3 | 4 |
| a. | Office for head of department |  |  |  |  |  |
| b. | Offices for consulting staff |  |  |  |  |  |
| c. | Reading room for residents |  |  |  |  |  |
| d. | Office for departmental secretary |  |  |  |  |  |
| e. | Regular administrative meetings |  |  |  |  |  |
| f. | Administrative meetings with residents |  |  |  |  |  |

Number of items scoring less than 2 …………………….

Percentage score ………………………

**C SUPPORTING UNITS.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | I MEDICAL RECORDS | 0 | 1 | 2 | 3 | 4 |
| a. | Space, lighting, ventilation |  |  |  |  |  |
| b. | Trained statisticians |  |  |  |  |  |
| c. | Efficient filling and retrieval system |  |  |  |  |  |
| d. | Computerization |  |  |  |  |  |
| e. | Good indexing |  |  |  |  |  |

Number of items scoring less than 2 …………………….

Percentage score ………………………

II PUBLIC HEALTH LABORATORY

Is there a public health laboratory in the department? YES/ NO

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Which of the following are routinely done there? | 0 | 1 | 2 | 3 | 4 |
| a. | **Urinalysis** by strips and microscopy |  |  |  |  |  |
| b. | **Haematology** Hb/PCV |  |  |  |  |  |
| c. | Total white cell count |  |  |  |  |  |
|  | **III Medical microbiology and parasitology** | 0 | 1 | 2 | 3 | 4 |
| a. | Stool and urine microscopy |  |  |  |  |  |
| b. | Blood for malaria parasites |  |  |  |  |  |
| c. | Blood for trypanosomes |  |  |  |  |  |
| d. | Blood for microfilaria |  |  |  |  |  |
| e. | Skin snips |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **IV Water Analysis** | 0 | 1 | 2 | 3 | 4 |
| a. | Bacteriological |  |  |  |  |  |
| b. | Chemical (specify) |  |  |  |  |  |

Number of items scoring less than 2 …………………….

Percentage score ………………………

**V PUBLIC HEALTH MUSEUM**

Is there one present YES/NO

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | AREAS WHICH HAVE BEEN SHOWCASED | 0 | 1 | 2 | 3 | 4 |
| a. | Epidemiology and disease control |  |  |  |  |  |
| b. | Environmental health |  |  |  |  |  |
| c. | Family and reproductive health |  |  |  |  |  |
| d. | Occupational health |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | INFRASTRUTURE OF THE MUSEUM | 0 | 1 | 2 | 3 | 4 |
| a. | Space |  |  |  |  |  |
| b. | Ventilation |  |  |  |  |  |
| c. | General cleanliness |  |  |  |  |  |

Number of items scoring less than 2 …………………….

Percentage score …………………….

VI VEHICLES.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | 0 | 1 | 2 | 3 | 4 |
| a. | Motorized vehicles |  |  |  |  |  |
| b. | Non motorized vehicles |  |  |  |  |  |

Percentage score ………………………

GRADING.

Not present 0

Below average 1

Acceptable 2

Above average 3

Excellent 4

**D HEALTH AND SAFETY.**

**FOR ALL FUNCTIONING AREAS.**

**Grade as: - Not Present 0 –– Below Average 1 – Acceptable 2 – Above Average 3 – Excellent 4**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **S/ N** | **ITEM** | **PRESENT/ ABSENT** | **GRADE** | **REMARKS** |
|  | Waste disposal. Bin removal and disposal |  |  |  |
|  | Electrical switches. No exposure of live conductors |  |  |  |
|  | Ladders and stairways in good condition |  |  |  |
|  | Protective clothing (lab coats, gloves heavy duty and latex, aprons) |  |  |  |
|  | Fire fighting equipment   * portable extinguishers * alarm systems * emergency exit doors |  |  |  |
|  | Safety equipment   * First aid box * eye wash bottles * emergency shower |  |  |  |
|  | Ergonomic factors   * seating adequate * accessibility of emergency exit ways |  |  |  |
|  | Documentation of incident/injury/needle stick/ reporting process |  |  |  |
|  | Hand decontamination |  |  |  |
|  | Biological safety cabinets |  |  |  |
|  | Protocols for universal precautions for handling blood and body fluids |  |  |  |
|  | Training programmes for laboratory personnel in safe working habits |  |  |  |
|  | Appointment of a safety officer |  |  |  |
|  | Are staff fully immunized against HBV |  |  |  |
|  | Protocol for disposal of infectious waste/  Pest control |  |  |  |

Number of items scoring less than 2 …………………………………..

Percentage score ……………………………………

**F QUALITY SYSTEMS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **ITEM** | **0** | **1** | **2** | **3** | **4** |
| **A** | Written quality document |  |  |  |  |  |
| **B** | Written protocols for patient care in the clinics |  |  |  |  |  |
| **C** | Written protocols for vaccines eg, recording of batch number, expiry date, recording temperatures on fridges and freezers etc |  |  |  |  |  |
| **D** | Written protocols for clinic records |  |  |  |  |  |
| **E** | Written protocol for out going records |  |  |  |  |  |
| **F** | Quality officer appointed and functioning |  |  |  |  |  |

Number of items scoring less than 2 …………………….

Percentage score ………………………

1. **ACADEMIC ACTIVITIES**

**GI STRUCTURE**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | ITEM | 0 | 1 | 2 | 3 | 4 |
| 1 | Departmental Library |  |  |  |  |  |
| 2 | Hospital library |  |  |  |  |  |
| 3 | Internet access |  |  |  |  |  |
| 4 | Seminar/conference room |  |  |  |  |  |
| 5 | Residents’ rest room |  |  |  |  |  |
| 6 | …………………………………………………………………….. |  |  |  |  |  |
| 7 | …………………………………………………………………….. |  |  |  |  |  |
| 8 | ………………………………………………………………………. |  |  |  |  |  |

Number of items scoring less than 2 …………………….

Percentage score ………………………

**GII ACTIVITIES**

|  |  |  |  |
| --- | --- | --- | --- |
| SERIAL NUMBER | ITEM | FREQUENCY PER MONTH | REMARKS |
| 1 | Grand round |  |  |
| 2 | Formal lectures |  |  |
| 3 | Tutorial |  |  |
| 4 | Research seminar |  |  |
| 5 | Case presentation |  |  |
| 6 | Journal presentation |  |  |
| 7 | Clinico-pathological conference |  |  |
| 8 | Other clinical postings |  |  |
|  |  |  |  |

Percentage score ………………………………………

**GIII : ASSESSMENT AND COUNSELLING.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | ITEM | 0 | 1 | 2 | 3 | 4 |
| 1 | Formative assessment as observed from Log books |  |  |  |  |  |
| 2 | Departmental communication on residents’ assessment |  |  |  |  |  |
| 3 | Evidence of mentoring |  |  |  |  |  |
| 4 | Evidence of communication between department and  hospital administration on formative assessment. |  |  |  |  |  |

Percentage score ……………………..

**H Observations:**

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**I General Recommendation based on Observations:**

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**Final Grading (0-4):** .........................................................................................................................

**Number of Residents on ground**

**Junior**……………………………………………………………………………………………………………………………….

**Senior** ...................................................................................................................................

**Recommendation for Training (Complete A or B)**

1. **Recommended for Accreditation/Re-Accreditation**

|  |  |  |
| --- | --- | --- |
| **Accreditation** | **Type** | **Period/Duration** |
| Full |  |
| Temporary |  |
| Partial |  |
| **Number of Residents for Training** | Junior |  |
| Senior |  |

1. **Not Recommended for Accreditation/Re-Accreditation**

**Reason(s) for denial of Accreditation**

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**Accreditation Team:**

1. .......................................................................... ...................................
2. ........................................................................... ...................................
3. ........................................................................... ...................................
4. ........................................................................... ...................................

**Coordinator of Training of Institution: Signature** ...........................................................................

**Name:** .......................................................................

**Hospital Director: Signature** ...........................................................................................................

**Name:** ...........................................................................................................

**Date of Visit:** ....................................................................................................................................

**Date received at College Secretariat:** .............................................................................................

**Signature of recipient:** ....................................................................................................................

Faculty Board Recommendations:

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**Faculty Chairman:** .............................................. **Faculty Secretary:** ..............................