Assessment Criteria

Intensive Care Unit

Sehat Sahulat Program

Name of Hospital: _____

Registration Number: _____

District:_____Tehsil:_____Urban/Rural:_____

Address: _____

No. of Beds (Registered):._____

Number of Beds (Max. Capacity): _____

Focal Person Name & Designation: _____

Focal Person Contact No: _____

Hospital/Focal person Email: _____

Assessment Done by: (Name, Signature, Stamp) _____

_____

Assessment Date: _____

Assessment Verified by: (Name, Sign and Date) _____

_____

The Performa will be filled by State Life Staff Only in consultation with respective medical facility & Signed by Hospital Focal Person

1. ACCESS TO ICU

- Open access ( )
- Closed access ( )
- Close with resterilization passage ( )

2. TYPE OF ICU

- Medical MICU ( )
- Surgical SICU ( )
- Pediatric medical/surgical PICU ( )
- Burn BCU ( )

3. ICU BED CAPACITY

3a. Total Beds (ICU Dedicated)

- Less than or equal to **4** ( )
- In the range of **5-9** ( )
- Equal to or more than **10** ( )

Specify Number: _____

3b. Ventilators

- In the range of **2-3** ( )
- Equal to or more than **4** ( )

Specify Number: _____

4. ICU DEDICATED STAFF

4a. ICU In charge ( )

a. Intensivist ( )

b. Medical Specialist Consultant / Pulmonologist / Anesthesiologist ( )

4b. Registrar/ Medical specialist evening coverage ( )

4c. Dedicated ICU MO. 24/7 ( )

- Less than or equal to **2** ( )
- Equal to or more than **3** ( )

Specify Number: _____

4d. Qualified ICU Nurse. (PNC registered) **( )**

- 5 or more Beds per Nurse ( )
- 4 Beds per Nurse ( )
- 3 Beds per Nurse ( )
- 2 Beds per Nurse ( )
- 1 Bed per Nurse ( )

Specify Number: _____

5. EQUIPMENT

List of Equipment required in ICU	**Is Available**	
Crash Cart	Yes ( )	No ( )
Beds with cardiac monitor	Yes ( )	No ( )
Infusion pump/ syringe driver	Yes ( )	No ( )
Suction Machine	Yes ( )	No ( )
Invasive BP monitor	Yes ( )	No ( )
BiPAP /CPAP	Yes ( )	No ( )
Temporary Pacemaker	Yes ( )	No ( )
Portable ECHO	Yes ( )	No ( )
Ultrasound	Yes ( )	No ( )
Portable X-ray	Yes ( )	No ( )
Defibrillator	Yes ( )	No ( )
ECG	Yes ( )	No ( )
CT ICU	Yes ( )	No ( )

6. SUPPORTING DEPARTMENT

Department Name	**Is Available**	
Cardiology(in house)	Yes ( )	No ( )
ABGs (inhouse) monitoring	Yes ( )	No ( )
Disinfection/sterilization	Yes ( )	No ( )

7. MANDATORY CHECKLIST

Description of checks	Is Available	
Every bed should have a monitor.	Yes ( )	No ( )
At least one defibrillator in ICU.	Yes ( )	No ( )
One staff nurse for 4 patients.	Yes ( )	No ( )
Availability of one Medical Specialist	Yes ( )	No ( )
Centralized Available Oxygen Supply	Yes ( )	No ( )
ACS (Acute Coronary Syndrome) protocol facility available for 24 Hrs	Yes ( )	No ( )
Anesthesia facility should be available inhouse .	Yes ( )	No ( )

8. MANDATORY PICTURES

Description of required picture	Is Available	
Picture front of ICU	Yes ( )	No ( )
Picture of ICU bed with ventilator and monitor	Yes ( )	No ( )
Picture of ICU ventilator	Yes ( )	No ( )
Picture of portable x-ray, ultrasound, ECG, Defibrillator	Yes ( )	No ( )
Picture of duty Roster (MO, Nursing staff) in ICU	Yes ( )	No ( )
Picture of ACS protocol in ICU	Yes ( )	No ( )