



Assessment Criteria

Neonatal 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 NICU

- **Open access** ()
- **Closed access** ()
 - Established SOPs, Access with shoe cover, gowns, sterilized environment ()
 - Established SOPs, Access with shoe cover, gowns, sterilized environment, with sterilization passage ()

2. BEDS DETAIL

2a. Beds Detail (Total Beds / Open Crib / Giraffe Bed / Bassinet)

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

Specify Number: _____

2b. Incubators / Incubator/ Isolette

- Less than or equal to **2** ()
- In the range of **3- 5** ()
- Equal to or More than **6** ()

Specify Number: _____

2.c Neonatal vent

- Less than 1 ()
- Equal to 1 ()
- Equal to 2 ()
- More than 2 ()

Specify Number: _____

3. NICU SPECIFIC HR

3a. Dedicated NICU MO. is available 24/7 (Roaster attach) ()

- Less than or equal to **2** ()
- Equal to **3** ()
- Equal to or more than **4** ()

Specify Number: _____

3b. No. of PNC certified nurses (Roaster attach)

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

Specify Number: _____

3c. In charge (Should not be assigned to any other task) ()

3.c-i-Neonatologist (MBBS/FCPS (Post Fellowship)) ()

Specify Number: _____

3.c-ii- Paed Specialist ()

Specify Number: _____

4. EQUIPMENT

List of Equipment required in NICU	Is Available	
Crash Cart/ Emergency Tray	Yes ()	No ()
Phototherapy Lights	Yes ()	No ()
Neonatal Radiant warmer	Yes ()	No ()
Suction Machine	Yes ()	No ()
Cranial USG	Yes ()	No ()
Laryngoscope	Yes ()	No ()
Temperature probe	Yes ()	No ()
Neonatal Defibrillator/ Cardioverter	Yes ()	No ()
Diaper scale	Yes ()	No ()
Portable x rays	Yes ()	No ()
BiPAP /CPAP	Yes ()	No ()
Portable EEG (Neonatal probs)	Yes ()	No ()
Cardio respiratory Monitor (Neonatal probs)	Yes ()	No ()
Bedside 2D-Echo (Neonatal probs)	Yes ()	No ()
Ultrasound (Neonatal probs)	Yes ()	No ()
Infusion pump/ Syringe driver	Yes ()	No ()
Intracranial pressure monitoring	Yes ()	No ()
Extracorporeal membrane oxygenator	Yes ()	No ()

Department Name	Is Available	
Paediatric Surgery	Yes ()	No ()
Paed's Cardiology Services	Yes ()	No ()
Anesthesia	Yes ()	No ()
Neurosurgery	Yes ()	No ()

6. OTHERS

Description	Is Available	
Inhouse ABGs available	Yes ()	No ()
NICU disinfection/sterilization (fumigation record)	Yes ()	No ()

7. MANDATORY CHECKLIST

Description of checks	Is Available	
THERMOREGULATOR: Ambient Temperature and Ventilation (72°F to 78°F).	Yes ()	No ()
Lactation support Comfortable seating, a handwashing sink, and means of communication to the NICU should be provided	Yes ()	No ()
Floor Surface should be cleaned (tiles laminated to avoid harboring of pathogen).	Yes ()	No ()
Dedicated In charge NICU should be available.	Yes ()	No ()
One staff nurse for 4 infants.	Yes ()	No ()
Availability of one Paed Specialist in morning time and on call in other shifts.	Yes ()	No ()
Availability of Emergency Crash card umbo bag and defibrillator	Yes ()	No ()

8. MANDATORY PICTURES

Description of required picture	Is Available	
Picture front of NICU	Yes ()	No ()
Picture of Incubators, crabs,	Yes ()	No ()
Picture of NICU ventilator	Yes ()	No ()
Picture of portable x-ray, ultrasound,	Yes ()	No ()
Picture of duty Roster (MO, Nursing staff) in NICU	Yes ()	No ()