NATIONAL POSTGRADUATE MEDICAL COLLEGE OF NIGERIA

Faculty of Pathology

APPLICATION FOR ACCREDITATION FORM

INSTRUCTIONS:

1. This form will be filled by the applying institution and returned to the College ahead of the visit. At each visit, there must be evidence presented to back up all claims by each centre. It is important that institutions try as much as possible to complete all sections of the form and do so truthfully

2. Institutions are to note that false information considered to be very serious might be a ground for denial of accreditation.

3. Ensure that all sections of the form are completed in very legible writing.

4. After completion and signings by the relevant persons, additional five copies should be made and all six copies returned by the institution to the College.
5. Completed forms accompanied by the appropriate application fee, in bank draft made payable to the National Postgraduate Medical College of Nigeria, should be returned to the College not later than two months after collection.

6. Place of purchase of application form, receipt number and date of purchase should be indicated in the spaces provided below.

7. No date of choice for the inspection should be indicated on any section of the form as no such provision has been made. The actual date of inspection shall be at the discretion of the College, but the institution will be communicated well ahead of the date. Where the chosen date is not suitable for the institution it shall so inform the College with a suggested date.

7. Place of purchase of Form: [ ]

8. Receipt Number & Date: .....

GENERAL INFORMATION ABOUT THE APPLYING INSTITUTION

1. Name & Address of Institution ……

……..

……..

……..

2. Name of Chief Medical Director ……

3. Name of Chairman, Medical Advisory Committee ……

……..

4. Bed-size of the Hospital ……

5. Number of Consultants in (a) Medicine …… (b) Surgery ……

(c) Paediatrics …….. (d) Obs/Gyn …….. (e) Anaethesia …… (f) Radiology……..

6. List Departments with current College accreditation status ……

……..

……..

……..

7. Attestation/Commitment: I, ……..

the Chief Medical Director of the afore-mentioned hospital hereby attest and commit the management and Board of the Hospital to abiding by all the rules, regulations and conditions for the training of Pathologists as specified and directed from time to time by the National Postgraduate Medical College of Nigeria and the Faculty of Pathology of the same College.

Signature & date ……

NATIONAL POSTGRADUATE MEDICAL COLLEGE OF NIGERIA
Faculty of Pathology

Standardized Accreditation Visits Form for Training Centres

All Questions should be answered by 1) Yes 2) No or 3) Not Applicable 4) specify number where required.
Some questions will require comments or more elaborate explanations; these should be made available in a brief and concise form

SECTION I: GENERAL

A. Laboratory Personnel:

1. Is the Head of Department a Pathologist qualified by training, expertise and experience in the areas of testing offered by the laboratory? ……..

Comments:
……
……
……

(The Head of Department must be a Fellow of the National Postgraduate Medical College of Nigeria (Pathology) or the West African College of Physicians or any foreign College whose Fellowship is recognized by the Faculty of Pathology of the NPMCN).

2. **If Head of department has delegated some responsibilities (*e.g.*, review of quality control data, procedure manuals, proficiency testing performance, *etc.*) to others, is there documentation of which individuals are authorized to act on his/her behalf for specific activities?**
…….

3. Is the Head of department a principal decision-maker in the selection of all laboratory equipment and supplies? …….

Comment:
……
……
……

4. a. Is there an organizational chart for the laboratory? …… ……
b. Is it visibly displayed? ……

5. Are there documented personnel policies? …….
Comment: ……..
……..
……

6. Do technical personnel records include all of the following mandatory items:

a. summary of training and experience ……
b. formal certification or license, if required by state …….
c. description of duties (may be generic to a position) ……...
d. records of continuing education ……...
e. records of radiation exposure where applicable (such as with *in vivo* radiation testing), but not required for low exposure levels such as certain *in-vitro* testing?
……..
(evidence will be required if the answers are yes**)**

Comment: ……
…….
…….
…….

7. Are there annual reviews of the performance of existing employees and an initial review of new employees within the first six months? (Evidence will be required if answer is yes)
…….

8. Are technical personnel tested for visual color discrimination? …… (Evidence will be required)

Comment: ……
…….
…….
(Technologists performing tests in hematology, chemistry, microbiology, and urinalysis should be tested for difficulty with visual color discrimination. Testing is not required for personnel who do not perform laboratory tests requiring color discrimination. Functional testing limited to discrimination of those colored items pertinent to the job is sufficient).

9. Does the general laboratory have adequate, conveniently located space so the quality of work, quality control procedures, safety of personnel, and patient care services are not compromised? ……
……..

10. Do all of the following areas have sufficient space and are they located so there is no hindrance to the work:

1. **Head Pathologist/Department …….**
2. **Pathologists and residents ……..**
3. **Clerical staff ……..**
4. **Chief lab scientist/laboratory manager ……**
5. **Laboratory scientists …….**
6. **Outpatient/ambulatory waiting and reception ……**
7. **lavatories ……**
8. **Library, conference and meeting rooms ……..**
9. **Personnel lounge/common room and lockers ……**

(All these will be inspected**)**

11. Are the room temperature and humidity adequately controlled in all seasons?
…….

12. Are passageways unobstructed? ……..

13. Are floors, walls and ceilings clean and well-maintained? …….

14. Are bench tops, cupboards, drawers and sinks clean and well-maintained?
…….

15. What are the different cadres of staff in the laboratory? ……
……
……
(Note: A submission of all staff, their qualifications and present status must be made available to the inspectors).

16. Are all staff computer literate?
…… (a randomly selected staff will be tested briefly by inspectors)

B. Emergency Services:

1 a. Do you run emergency services? ……..
b. What is the time frame? …….

2. Who runs the emergency units?
……..……
……..……
……..

3. How are reports sent to the patients during emergency periods? ……
……..……
……..……
……

4. What tests are carried out during the emergency period? ……..

…….

…….

…….

……

5. What is the turn around time for each test? ……

……..

……..

……..

……..

……..

……

6. Is there a call duty room available for personnel on call? …….

(this will be inspected**)**

C. Records:

1. **How are laboratory records kept? ……**

……

…….....

.....

(Records will be inspected)

2. **Is the laboratory computerized? ……**
3. **Is there a network system available in the computer system? …….**
4. **How long are records kept before being destroyed? ……..**
5. **Are results of tests easily traceable? ……..**

D. Quality Laboratory Testing:

1. Does the laboratory participate in any external proficiency testing program? ……. Give details if you answered yes; last two reports will be inspected)

……
……
……
……
……

(Each laboratory is expected to participate in at least one external quality assurance programme)

2. Does the laboratory have a performance assessment system for determining the accuracy and reliability of analytic results on patient samples for which no external proficiency testing program is offered?

……

(This may be accomplished through blind testing of specimens with known results, exchange of specimens with other laboratories, or other equivalent systems specifically recommended and approved by the head of department. Inspectors will examine documented evidence of this)

3. **Is the above alternative performance assessment system exercised at least semi-annually?**
…….

4. **Has the Head of department or designee reviewed the results from the above alternative performance assessment system? ……** ……..

(The Laboratory Head of department must review all results from the alternative performance assessment system)

5. **Does the Laboratory head of department or consulting Pathologist participate in mortality reviews of the various clinical departments?** ……..

6. **Is there a systematic program to identify and correct problems that may interfere with patient care services? ……**
……
(There must be an organized method for documentation of all identified problems, irrespective of which shift or in which laboratory section they occur. There should be an emphasis on clinical issues. Laboratories must be involved in the root cause analysis of any unexpected event involving death or serious physical or psychological injury (or risk thereof) involving the laboratory; laboratories must be able to demonstrate appropriate risk-reduction activities based on such root cause analyses. Resolution of the problems must be documented).

7. Are the clinicians and other hospital workers involved in the quality programs of the laboratory? (medical, surgical, nursing services, *etc.*)? ……..
……
…….
(The Head of department should co-ordinate a program to involve the physicians and other personnel involved in patient management. The intent is to consider Quality Improvement of patient care services a medical process. There should be evidence that one or more improvement activities were chosen after consultation with the medical or nursing staff. Seminars and orientation courses should be organized in each hospital by the Laboratory staff to intimate them of their roles in producing reliable laboratory results).

8. **Is there any measure put in place to assess clinician and patients' satisfaction with the laboratory service? ……..**

(The laboratory should measure the opinion of its client physicians and patients regarding its services. Indicators of physician satisfaction include referral statistics and complaint rates. Measuring patients' satisfaction with the phlebotomy service is appropriate. Inspectors may interview some medical personnel and patients picked at random to seek their views on how they perceive the pathology services).

9. a. **Is there a structured quality control program available in the laboratory? …….**
…… b. Does this program clearly define goals for monitoring analytic performance, procedures, policies, tolerance limits, corrective action, and related information? …….
……..
……..

10. For those tests performed using different methodologies or instruments or at different testing sites, is there a defined mechanism to verify the comparability of patient results throughout the clinically appropriate ranges? ……..

11. Are controls run for every test available? ……

12. How many levels of controls are run per test? ……

13. Are the QC results plotted on charts? ……

(The charts must be made available for the past 1 year).

14. What are the sources of your control materials? ……..
……
……
……

15. Has the laboratory conducted an interim self-inspection and documented efforts to correct deficiencies identified during that process? ……
……
……
(The laboratory must provide the inspector with documentation of the above.
The laboratory must have a policy and procedure in place to conduct an interim self-inspection and take corrective action for deficiencies found. The interim self-evaluation inspection is an important aspect of education and laboratory improvement. All mechanisms for self-evaluation (use of residents, technologists or other inspectors) and maximum utilization of the process for continuing education and improvement are strongly endorsed).

16. **How many sections do you have in the laboratory? ……**
(A list of all the laboratory divisions should be made available, e.g. main laboratory, automation unit etc).

17. **Do you have rooms allocated to the laboratory staff? ……**
……
…… ……
(Laboratory staff such as the Pathologists, laboratory scientists, maids, etc)

18. **Is the ambient temperature of the laboratory maintained and monitored? ……**

(The ambient temperature must be between 18-25^{0}C. Thermometers used for this purpose must be made visible. There must also be proper documentation of the daily checks).

19. **Are the temperatures of the refrigerators and freezers monitored? ……**

(Monitoring thermometers should be made available).

20. a. Is there a standard operating procedure for the storage of samples and also for disposing of samples? ……
b. How long are the samples kept before being disposed of?
……

……
……

21. Is there a procedure manual or other source for the complete collection and handling instructions of all laboratory specimens? ……..
……
……

22. Is the specimen collection manual distributed to all specimen-collecting areas within the hospital (nursing stations, operating room, emergency room, out-patient areas) ……

23. Does the specimen collection manual include instructions for all of the following elements, as applicable:

a. preparation of the patient, ……..
b. type of collection container and amount of specimen to be collected, ……
c. need for special timing for collection (*e.g.*, creatinine clearance, microfilaria),
……
d. types and amounts of preservatives or anticoagulants, ……
e. need for special handling between time of collection and time received by the laboratory (*e.g.*, refrigeration, immediate delivery), ……
f. proper specimen labeling, ……..
g. need for appropriate clinical data, when indicated? ……..

24. a. Is there a phlebotomy room in the hospital? ……
b. Does the room have the necessary equipments like a tray with all the bottles, couch, comfortable chairs and a first aid box? ……
……
……
……

25. a. Are there trained phlebotomists handling these procedures? ……
b. Are they trained to handle emergencies? ……..

26. Is there documentation that all personnel performing patient blood collection have been trained in the proper selection and use of equipment/supplies, and collection techniques? ……..
……
……
(The laboratory should maintain records demonstrating that all personnel performing patient blood collection have been trained in the proper selection and use of equipment/supplies and collection techniques)

27. Do phlebotomists use only non-latex or powder-free latex gloves during patient contact?
……

28. Does the specimen collector positively identify the patient before collecting a specimen?
……

(The patient must be positively identified before the blood specimen is collected. Identification containing at least patient name and hospital number should be attached to the specimen at the collection site, and not deferred until some later time/location where errors may occur.
Inspectors are expected to watch such a procedure).

29. **Has the laboratory reviewed its specimen collection manual and phlebotomy practices to minimize unnecessarily large or small blood draw volumes? ……..**

30. Is there a mechanism to provide feedback to phlebotomists on issues relating to specimen quality?
……..

(There should be a mechanism for the laboratory to provide feedback to phlebotomists on how their collection techniques impact on specimen quality. The accuracy of an analytic result depends upon the initial quality of the specimen, so that proper procedures at the time of phlebotomy are essential).

31. What Transport facilities are available in the hospital for laboratory specimens?
…….
…….
…….

32. Are the hospital maids trained in appropriate safety and packaging procedures suitable to specimen type and distances transported? ……..
…….

(Transport personnel should be trained in appropriate safety and packaging procedures suitable to specimen type and distances transported. This should include issues such as adherence to regulations for transport of biohazards, use of rigid containers where appropriate, temperature control, notification procedures in case of accident or spills, timing and speed, *etc)*

33. Is there a documented system to ensure that all specimens submitted to the laboratory are actually received? ……
(Document will be inspected by inspectors)

34. **Are all specimens accompanied by an adequate requisition/consultation form? ……..**

35. **Does the consultation form include all of the following elements, as applicable:**

a. adequate patient identification information (*e.g.*, name, location and hospital number
…….
b. name and address of physician or legally authorized person ordering the test,
…….
c. tests or assays requested, …….
d. time and date of specimen collection when appropriate ……..
e. source of specimen, when appropriate ……..
f. clinical information, ……..

36. Does the laboratory have a mechanism to ensure that specimens are analyzed only at the request of a physician/consultant? …….

37. Has the laboratory evaluated its specimen containers to ensure that they do not contribute to analytic interference in the assays to be performed? …….

(The laboratory should evaluate its specimen containers to ensure that they do not contribute to analytic interference in the assays to be performed. This may be done through some combination of direct testing by the laboratory, review of the clinical literature, and evaluation of information from manufacturers)

38. **Is the reportable range verified/established and validated for each analytic procedure before implementation? …….**
(The laboratory must verify or establish the reportable range of patient test results before implementing an assay. The reportable range includes all results that may be reliably reported, and embraces two types of ranges)

a. The ANALYTICAL MEASUREMENT RANGE- is the range of analyte values that a method can directly measure on the specimen without any dilution, concentration or other pretreatment not part of the usual assay process.
b. The CLINICALLY REPORTABLE RANGE- is the range of analyte values that a method can measure, allowing for specimen dilution, concentration, or other pretreatment used to extend the direct analytical measurement range.

The limits of the reportable range are based on meeting accuracy and precision requirements such as the minimal limit of quantification or sensitivity, when applicable. In some cases, clinically relevant limits may be narrower than the potential analytical range, and the clinically relevant limit would be used as the limit of the reportable range.

39. **Has the laboratory established or verified its reference intervals (normal values)?**
……

(The laboratory must establish or verify its reference intervals. The reference interval must be established or verified for each analyte and specimen source (*e.g.*, blood, urine, cerebrospinal fluid), when reasonable. For many analyte (*e.g.*, therapeutic drugs), literature references or a manufacturer's package insert information may be appropriate).

40. **Where appropriate, do laboratory reports include name of the ordering physician?**
……
……
(This should be included in all reports)

41. Do reports show the date and time of release (or if not on the report, are the date and time readily accessible when needed, as appropriate)? ……..

42. Are reference intervals (normal ranges) listed for each reported test where possible? ……
(Inspectors will randomly pick reports to observe)

43. **Are results from automated instruments transcribed into patient's forms or are the computer sheets attached to the forms? ……**

44. **Are copies or files of reported results retained by the laboratory in a manner that permits prompt retrieval of the information? ……..**
…….
(Record of the last two years will be inspected**)**

45. Does the chief laboratory scientist attest to the technical competence of these tests?
…….
…….
(The chief laboratory scientist's signature on the test result implies that he has certified the technical competence of the tests, and therefore shares in any liability).

46 a. Are laboratory results signed out and reported by a Pathologist? ……...
(The Pathologists have the overall responsibility for the quality of results emanating from their laboratories. Therefore, the Pathologist must review all results, make his comments where necessary and sign them out. The Pathologist may delegate some of his duties to competent juniors but he/she remains liable if anything goes wrong).

46 b. Is the Pathologist involved in the procurement of equipment and reagents for the laboratory?
…….
Specify the level of involvement ……...
…….
…….
(Since the Pathologist is responsible for the overall quality of results from his/her laboratory he/she must be involved in ALL processes leading to the procurement especially in the selection of type/model, manufacturer, volume or quantity, selection of suppliers and technical analysis of bids or quotations. He/she must also approve of any of such supplies before they are received or paid for).

47. Does the laboratory have procedures for immediate notification of a physician (or other clinical personnel responsible for patient care) when results of certain tests fall within established "alert" or "critical" ranges? ……..

48. **Is there a list of critical values on display in the laboratory? ……**
(The laboratory must have complete procedures for immediate notification of a physician (or other clinical personnel responsible for patient care) when test results fall within established "alert" or "critical" ranges. This includes results received on specimens sent to reference laboratories for testing. Alert or critical values represent those results that prompt rapid clinical attention to avert significant patient morbidity or mortality. These values should be defined by the Laboratory Pathologists, in consultation with clinicians served).

49. **Is there documentation of notification of the appropriate clinical individual of all critical values on any laboratory test? ……**
……

50. **Has the laboratory defined turnaround times (*i.e.*, the interval between specimen receipt by laboratory personnel and results reporting) for each of its tests, and does it have a policy for notifying the requester when testing is delayed? ……..**
……..
……..
(The laboratory must have defined turnaround times for each of its tests, and a policy for notifying the requester when testing is delayed. This does not mandate that clinical personnel be notified of all delays in testing, but only in those situations mutually agreed upon as essential by clinical and laboratory personnel. Turnaround time is defined as the interval between specimen receipt by laboratory personnel and results reporting).

51. **Are laboratory records and materials retained for an appropriate time? …….**
……..

(The following records must be retained for at least 2 years: specimen requisitions (including the patient chart or medical record only if used as the requisition), patient test results and reports, instrument printouts, quality control records, instrument maintenance records, proficiency testing records. Serum and body fluid specimens should be retained for 48 hours. Urine specimens should be retained for 24 hours. Blood films, permanently stained body fluid slides, and microbiology slides should be retained for 7 days).

52. Has the laboratory defined the specific type of water required for each of its testing procedures?
…….
…….

(The laboratory must define the specific grade of water necessary for each of its procedures. For commercial instrument-reagent systems, the laboratory may use a specific type of water recommended by the manufacturer. Commercial sources of water may be acceptable for specific applications -- the user laboratory should periodically check its water to ensure that undesirable changes have not occurred between time of production (or purchase) and use).

53. **Are there appropriate documented procedures for handling and cleaning glassware, including methods for testing for detergent removal? …….**
……

(The laboratory must have completely documented procedures for all aspects of glassware handling and washing, including methods for testing for detergent removal. Special instructions for micropipettes, cuvets, acid washing, *etc*. must be included).

54. **Has the laboratory verified or established and documented analytic accuracy and precision for each test? …….**
……..

(Where current technology permits, accuracy is established by comparing results to a definitive or reference method, or may be verified by comparing results to an established comparative method. Use of reference materials or other materials with known concentrations or activities is suggested in establishing or verifying accuracy. Precision is established by repeat measurement of samples at varying concentrations or activities within-run and between-run over a period of time).

55. **Has the laboratory verified or established and documented the analytic sensitivity (lower detection limit) of each assay, as applicable? ……..**

56. **Has the laboratory verified or established and documented analytic interferences for each test?**
……..

57. **Are the instruments adequately protected against electrical power interruptions and surges?**
……..

(The computer system and other automations must be adequately protected against unexpected power interruptions and surges. An un-interruptible power system UPS must be considered).

58. **Are procedure manuals clearly documented, complete and readily available to all authorized users?**
……..

59. Does the system provide for comments on specimen quality that might compromise the accuracy of analytic results (*e.g.*, hemolyzed lipemic)? ……

E. General/Laboratory safety:

1. Is general intralaboratory communication effective and efficient? ……

2. Are telephones and computer terminals conveniently located? …….

3. Is the intralaboratory storage area sufficient? ……

4. Are storage areas well-organized and free of clutter? ……...

5. Are safety policies and procedures posted or readily available to all personnel? …….....

6. Have policies and procedures been developed regarding the documentation of all laboratory accidents resulting in property damage or involving spillage of hazardous substances? …… ……

7. a. Is there a well stocked first aid box in the laboratory? ……
b. Is it being checked regularly? ……..

8. Are policies and procedures documented and adequate for fire prevention and control? ……. ……. …….

9. Have personnel been instructed in the use of portable fire extinguishers? ……

10. Does the laboratory have a Chemical Hygiene Plan (CHP) that defines the safety procedures for all hazardous chemicals used in the laboratory? ……..

(An acceptable CHP contains the following elements:

a. responsibilities of Head of Department and supervisors;
b. designation of a qualified individual as the chemical hygiene officer;
c. policies for all operations that involve the use of hazardous chemicals;
d. criteria that will be used to determine the need for engineering controls, personal protective equipment, and hygiene practices;
e. criteria for exposure monitoring when there is reason to believe that permissible exposure levels are routinely exceeded;
f. provisions for medical consultations and examinations whenever signs or symptoms of exposure occur or whenever monitoring reveals employee exposures are above the action level permissible exposure level;
g. provisions for training employees in the element of the CHP)

11. Are policies and procedures documented and adequate for hazardous waste disposal? …… …….

12. Is there a comprehensive, documented and workable evacuation plan, in case of a fire outbreak? …….

13. Does the laboratory have a documented policy for infection control? ……...

(There should be an Infection Control Committee and the Infection Control Team domiciled in the Department of Medical Microbiology & Parasitology. Activities of both the Committee and the team must be well documented. The infection control antibiotic policy, antiseptic use policy etc must be contained in the infection control manual of the hospital, and reviewed periodically. The inspectors will examine the antibiotic susceptibility profile of the hospital isolates for the last two years)

14. Are there documented procedures detailing procurement, transportation, and handling of patient specimens (blood, body fluids, tissue) to ensure that all specimens are submitted in an appropriately labeled and well-constructed container with a secure lid to prevent leakage during transport?
…….

15. Are there documented procedures for handling spills of blood and other body fluids? ……..
…….

16. Is Mouth Pippetting still practiced? …….

17. Have personnel been instructed in the proper use of personal protective clothing/equipment (*e.g.*, gloves, lab coats, face masks *etc.*)? ……

18. a. Have all personnel reasonably expected to have direct contact with body fluids received education on precautionary measures, epidemiology, modes of transmission and prevention of human immunodeficiency virus (HIV), hepatitis C virus (HCV) and hepatitis B virus (HBV) and the application of "universal precautions" or "standard precautions" to their work practices?
……

18. b. Is there provision for needle stick or post-exposure prophylaxis for staff? ……

19. Have personnel reasonably expected to have direct contact with body fluids been identified and offered hepatitis B vaccinations free of charge? ……

20. Does the laboratory have a documented tuberculosis exposure control plan?.....

21. Does the Policies and Procedures Manual prohibit smoking, eating, drinking, application of cosmetics and lip balm, manipulation of contact lenses, and mouth pipetting in all technical work areas?
……

22. Are the chemical fume hoods functional? ……..

23. Are supplies of flammable and combustible liquids reasonable for the laboratory's needs, and are they properly stored? ……..

24. Are all infectious wastes (*e.g.*, glassware, blood collection tubes, specimens, bacteriologic) and other solid or liquid waste or refuse discarded into "biohazard"-labeled containers that do not leak and have solid, tight-fitting covers that are applied before transport from the laboratory work area for storage and disposal? …….
…….

……

F. Laboratory Equipments:

A list of all available functional equipments are to be inspected and seen to be working by the inspectors.

1. **Is the laboratory fully automated or partially automated or not automated at all? ……..**
……..

2. **Are manual methods still in use? ……..**

3. **Are there enough well trained personnel to man the various benches? ……**

4. **How often are the various instruments calibrated? ……..**

5. **Is there a maintenance contract for the repairs of the instruments? ……..**

6. **What is the average down-time for the automated instruments per week. ……**

……..

(Should be presented in form of a table - for all instruments)

G. Residency Training:

1. **How many residents are on ground? ……**

(A list of all residents should be presented in a format to include the senior and junior residents and those on rotation).

2. **Do the residents participate in routine analysis? ……**

(Residents must be involved in routine sample analysis as part of their training. The supervising Pathologist shall determine when the Resident shall start participating in the bench work, including call duties).

3. Is there a residency training program in the department? ……..

(A copy of the program is to be submitted)

4. Do residents take calls? …….
Briefly state what they do during this period? …….
…….
…….
…….
(Residents shall routinely take laboratory and clinical calls as may be decided by the Pathologist. Only Pathologists shall provide cover for residents on laboratory call. On no account shall a Resident be paired on call with a medical laboratory scientist. A resident on call shall be on duty alone with support/cover provided by

the Pathologist. Call duty roster for the current and three previous months will be inspected by the accreditation inspectors and copies made available).

5. a. Do the residents participate in running clinics e.g. STI & Infectious Diseases, Metabolic, Haematology, Cytology etc? ……

b. Is the clinic primarily run by the Department? ……

(Clinics and records will be inspected)

7. Do the residents participate in consultative rounds with the consultants? ……

8. Are there provisions for the Department to admit and manage in-patients? ……

9. Are the consultants fully involved in the training program of the residents? ……..

……

(a copy of weekly/monthly training programme should be made available)

10. Is there an arrangement in place to send the Residents to other centres where facilities are available to makeup for deficiencies in your centre. ……

(Only the Head of Department or supervising Pathologist shall determine when a Resident shall embark on such external attachment).

11. What arrangements are available for funding research in the Deaprtments or institution?

……

…….....

.....

……

(As a training institution at the highest level research must be one its main activities. Therefore the institution should have provision for funding staff and residents' research and for sponsoring them to scientific meetings where research issues are discussed. Inspectors will take note of on-going research work in the Departments).

12. Are the Residents provided with basic working/training tools eg a microscope each, a slide projector for each Department etc? (be specific) ……..

……..

……..

……..

13. Are Library facilities available? ……

……

……

The library should have current textbooks, atlases and journals. Journals on tropical diseases are mandatory. The National College Journal and any three other indexed local journals must be available regularly. Electronic access to journals and other resource materials are acceptable.

14. Will a resident who wishes to pursue a Masters or PhD degree in his discipline during the Residency programme be allowed to do so? ……..

(This can only be allowed after passing the Part I examinations)

15. Is there a separate Residents' room? ……..
(Residents' room should be spacious enough to comfortably seat all the residents in the Department. It should also have a white board, and a corner for carrying out some basic laboratory procedures. Residents' learning materials should be seen in the room)

SECTION II: MEDICAL MICROBIOLOGY & PARASITOLOGY CHECK-LIST

1. Laboratory space (excluding administrative offices): Indicate No and sizes (metre square)

1.1 Reception and registration room ……..

1.2 Changing room ……

1.3 General Laboratory Room ……

1.4 Special culture room - for TB/Mycology with dedicated microscopes …….

1.5 Immunology room ……..

1.6 Media room …….

1.7 Wash-up, autoclave and sluice room …….

1.8 Waste disposal facilities especially needles and sharps …….

1.9 Residents room with one microscope for each resident, and a white Board for lectures ……..

1.10 Call-duty room. ……

1.11 Restroom ……..

1.12 Bathroom ……..

1.13 PCR Rooms ……

1.14 Clinic Rooms ……

1.15 Bed Space for In-patients ……

2. Equipment – Indicate No and state of functionality (Use F for functional, NF for non-functional and NA for not available)

2.1 Standard binocular microscopes – one per sample bench unit ……
(excluding dedicated ones for TB and Malaria parasite work)

2.2 Research and teaching microscopes (digital with photographic facilities and screen/accessories) - one per Consultant, and also multi-headed microscope ……...

2.3 Fluorescent Microscope ……...

2.4 Autoclave (specify type) ……...

2.5 Refrigerators, at least 3 (1 – prepared media; 1 – specimens; 1- reagents) ……...

2.6 Deep Freezers (at least 1minus 20^0C; 1 minus 70-80^0C) ……..

2.7 Hot air oven …….

2.8 Incubator ……..

2.9 CO_2 Incubator ……..

2.10 Water bath ……..

2.11 Shaker ……

2.12 Distilling Apparatus ……

2.13 Chemical balance ……

2.14 Safety Cabinet (Class 2 or 3) …….

2.16 ELISA Reading Machine and Washer ……..

2.17 Automated Blood culture facilities ……

2.18 Automated Mycobacterium culture facilities ……...

2.19 PCR Machine ……..

2.20 General laboratory wares, e.g. Bunsen burner, staining racks, counting chambers plaiting loops, anaerobic jar.
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2.21 Adequate consumables, e.g. culture plates, media, sensitivity discs, slides and cover-slips; and reagents. (List media and reagents, including antibiotic sensitivity testing disks readily available in the Laboratory. Inspectors will observe them and have a look at your store) …….....

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2.22 Evidence of source of sheep blood. (Human blood not acceptable for work).
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3. Personnel: Indicate No and Qualifications

3.1Consultants (Fellow of the National Postgraduate Medical College of Nigeria or equivalent) – Specify names and qualifications ……
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3.2 Medical Laboratory Scientists – minimum of four. ……

3.3 Other supporting staff – Scientific Officers/Medical Laboratory Technicians/Assistants and Attendants.
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3.4 Secretary and Office Assistants. ……
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(Indicate name of Departmental Secretary. Absence of a satisfactory Departmental Secretariat might on its own provide sufficient grounds for denial of accreditation).

4. **Scope of Services: (Indicate by using 'A' for available, 'NA' for not available, 'AL' for available but limited, and 'NACD' not available but can be done)**

4.1 Throat Swabs. ……

4.2 Sputum – including Z-N stain for AFB, culture and sensitivity. Be specific. ……
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4.3 Urethral/Vaginal Swabs. ……..

4.4 Blood culture. ……

4.5 Skin biopsy and nasal smears, including parasites and fungal …….

4.6 Urine – urinalysis, microscopy and culture/sensitivity ……

4.7 Stool – parasites, culture/sensitivity ……...

4.8 CSF – cell count, microscopy, culture/sensitivity …….

4.9 Pus and other swabs, wound biopsy, aspirates, scrapings, ……..

4.10 Immunology – Hepatitis profiling, VDRL, Widal, ASO titre, HIV, Pregnancy, other viral immunology,etc. …….

4.11 Bacteriology of water, food ……..

4.12 Determination of serum drug levels. ……..

4.13 Molecular Diagnosis – PCR …….

5. Clinical Programmes/Laboratory Programmes

5.1 STI Clinic ……

5.2 Infectious disease clinic. ……..

5.3 Follow-up clinics ……

5.4 Infection control and Audit ……...

5.5 Bench rounds …….

5.6 Call duties (Lab & Clinical) ……..

5.7 Ward Rounds in Internal Medicine (even if the Department admits patients) ……

5.8 Postings to other Departments – Internal Medicine, Paediatrics, Surgery, Radiology ……..
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6. Academic Programme

6.1 Structured Postgraduate Teaching Programme: Seminars, tutorials and bench rounds. ……

6.2 Clinico-Pathological Meetings (intra and inter-departmental). ……...

6.3 Journal Review Club …….

6.4 Research Methodology and Statistics ……...

6.5 Management programme ……

6.6 Computer acquisition skills, especially words, excel, power-point and internet browsing ……

6.7 Quality Assurance Programme ……...

Head of Department
Name: ……..
Qualification(s) ……
Signature …… Date ……

SECTION III: CHEMICAL PATHOLOGY

A. **Laboratory Space: (excluding administrative areas)**

1. Emergency test laboratory (may be at the Emergency dept of the hospital)
2. Reception and separation room
3. Routine laboratory
4. Automation Unit
5. Special Test Laboratory
6. Research Laboratory
7. Common Rooms with Lockers
8. Laboratory Information System Room (Computer Room)
9. Offices for Chief Med. Lab Scientists, Consultants, residents and other staff
10. Departmental library
11. Departmental seminar rooms
12. Store and wash-up rooms

B. **Equipment and Consumables (Must be made available for residents training)**

Flame photometer

Spectrophotometer (including U. V. wave lengths)

Colorimeter

Water Bath

Electrophoretic Tank and power pack

PH meter

Centrifuges

Deep Freezer

Refrigerators

Water Distiller

Deioniser

Adjustable automatic diluter

Automatic Pipettes

Osmometer

Fluorimeter

Blood Gas Analyzer

Atomic Absorption Photometer

Microtiter Plate Reader/Washer (ELISA)

Electrophoresis/densitometer Scanner

Automated Analyzers

General laboratory wares,
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Adequate consumables, e.g. reagents and chemicals (Inspectors will observe them and have a look at your store)
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C. Personnel: Indicate No and Qualifications

C.1Consultants (Fellow of the National Postgraduate Medical College of Nigeria or equivalent) – Specify names and qualifications ……
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C.2 Medical Laboratory Scientists – minimum of four. …….

C.3 Other supporting staff – Scientific Officers/Medical Laboratory Technicians/Assistants and Attendants.
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C.4 Secretary and Office Assistants. ……
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(Indicate name of Departmental Secretary. Absence of a satisfactory Departmental Secretariat might on its own provide sufficient grounds for denial of accreditation).

D. **Tests Available: (Please List)**

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E. Clinical/Laboratory Programmes

E.1 Endocrine and Metabolic Clinic run by the Chemical Pathologists
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E.2 Follow-up clinics ……

E.3 Bench rounds …….

E.4 Call duties (Lab & Clinical) ……..

E.5 Ward Rounds in Internal Medicine (even if the Department admits patients) …….

E.6 Postings to other Departments – Internal Medicine, Paediatrics, Surgery, Anaesthesia ……...
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F. <u>Academic Programme:</u>

F.1 Structured Postgraduate Teaching Programme: Seminars, tutorials and bench rounds. ……

F.2 Clinico-Pathological Meetings (intra and inter-departmental). ……...

F.3 Journal Review Club ……

F.4 Research Methodology and Statistics ……...

F.5 Management programme ……

F.6 Computer acquisition skills, especially words, excel, power-point and internet browsing ……

F.7 Quality Assurance Programme ……...

Head of Department
Name: ……..
Qualification(s) ……
Signature …… Date ……

SECTION IV: HAEMATOLOGY & BLOOD TRANSFUSION

HAEMATOLOGY AND BLOOD TRANSFUSION (ON THE SPOT ASSESSMENT)

A. <u>Laboratory space:</u> (Excluding administrative offices)

I. Reception and separation

II. Routine Laboratory

III. Special Tests Laboratory

IV. Postgraduate Laboratory

V. Blood Bank and Cross match Laboratory

VI. Phlebotomy Room

VII. Counseling Room

VIII. Sensitive equipment room

IX. Blood products Laboratory

X. Donor Room

XI. HIV Laboratory

XII. PCR Rooms

XIII. Seminar Room

XIV. Day care Ward

XV. Consulting Room

B. **Equipment**

Specimen mixer

Microhaematocrit centrifuge

Colorimeter for Hb

Spectrophotometer

Waterbath

Incubator

Bench centrifuge

Hot air oven

Refrigerator

Deep freezer

Hb electrophoresis system

Analytic Weighing balance

Ph meter

Sterilizer

Automated cell counter

Automated staining machine

Bone marrow needle

Blood bank refrigerators

Refrigerated centrifuge

Microscopes

Teaching Microscopes

Cell Separator

Viscometer

Automated coagulometer

Flow cytometer

PCR

Laminar Flow Cabinet

Fume Cupboard

ESR Equipment – Westergreen and Winthrobe

Distiller

Computer/multimedia

Cytospin

Fluorescent Microscope

Weighing scale

Sphygmomanometer

Stethoscope

C. Personnel: Indicate No and Qualifications

C.1Consultants (Fellow of the National Postgraduate Medical College of Nigeria or equivalent) – Specify names and qualifications ……
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C.2 Medical Laboratory Scientists – minimum of four. ……..

C.3 Other supporting staff – Scientific Officers/Medical Laboratory Technicians/Assistants and Attendants.

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C.4 Secretary and Office Assistants. ……
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(Indicate name of Departmental Secretary. Absence of a satisfactory Departmental Secretariat might on its own provide sufficient grounds for denial of accreditation).

D. **Scope of services** (state approximate turnover per year).

Routine blood counts, films and differential counts,

Sickling tests, Hb electrophoresis,

Routine coagulation test (PT, PTTK, WBCT),

Special stains (iron, SBB) PAS, etc.,

Iron profile (Fe, TIBC, Ts) etc,

B12 assays, folate assays, G-6-P-D assays,

Coagulation profile,

Blood grouping and crossmatch,

Antibody detection, Coombs test,

Blood products,

Paternity testing,

Viral screening tests for transfusion transmissible infections

E **Clinical Programmes For Haematology**

Bone marrow studies,

Hb clinic,

Haemato-oncology clinic,

coagulopathy clinic,

HIV clinic,

Ward rounds,

Emergency/day care services

F. **Academic programmes:**

Slide/Bone marrow reviews,

Seminars,

Clinicopathologic rounds,

Journal club,

Research seminars

Pathology grand rounds

SECTION V: MORBID ANATOMY/HISTOPATHOLOGY

HISTOPATHOLOGY (MORBID ANATOMY)

LABORATORY SPACE: (excluding Administrative offices)

Surgical Pathology Reception

Cut-up room

General Laboratory

Histochemistry Laboratory

Wash-up room

Cytology Reception and Laboratory

Mortuary with adequate storage facility

Postmortem Theatre

Pathology Museum

FNAB Clinic

Seminar Room

Residents Room

EQUIPMENT

Tissue processor

Wax bath

Paraffin oven

Embedding moulds

Microtome

Weighing scale

Knife sharpener

Binocular microscopes

Dissecting microscope

Teaching Microscope

Multimedia Projector

Microscope slide projector

Cryostat

Liquid nitrogen tank

Deep freezer

Laboratory refrigerators

Table centrifuge

Cytospin

Water distiller

Flow Cytometer

PCR

Computers

PERSONNEL

C. Personnel: Indicate No and Qualifications

C.1Consultants (Fellow of the National Postgraduate Medical College of Nigeria or equivalent) – Specify names and qualifications ……
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……
……

C.2 Medical Laboratory Scientists – minimum of four. …….

C.3 Other supporting staff – Scientific Officers/Medical Laboratory Technicians/Assistants and Attendants.
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C.4 Secretary and Office Assistants. ……
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(Indicate name of Departmental Secretary. Absence of a satisfactory Departmental Secretariat might on its own provide sufficient grounds for denial of accreditation).

SCOPE OF SERVICES

Tissue biopsies,

Papanicolau smears,

Fluid cytology requests,

FNA Cytology,

Special stains,

Immunohistochemistry,

Flow cytometry,

Molecular studies,

Frozen Sections,

Post mortems,

Embalmment

CLINICAL PROGRAMMES:

FNA Clinic

inicopathological conferences

Mortality reviews

Clinical ward consultations

ACADEMIC PROGRAMMES:

Slide reviews, seminars

Clinicopathologic rounds

Journal club

Research seminars and

Pathology grand rounds

Chief Medical Director
Name: ……
Signature…… Date …….
Official Seal or Stamp