



AFPI CLINIC ACCREDITATION SELF ASSESSMENT CHECKLIST

PURPOSE OF THE SELF-ASSESSMENT CHECKLIST

This self-assessment checklist has been designed as a **reflective and developmental tool** for Primary Care Clinics applying to the AFPI Accreditation Programme. Its primary purpose is to help clinics evaluate their current practices against the accreditation standards and to identify areas requiring improvement in the delivery of safe, effective, and patient-centered care.

The responses will also provide the AFPI assessment team with a clear understanding of the clinic's present status and the type of support that may be required to achieve full compliance with accreditation standards.

Applicants are strongly encouraged to complete the checklist with **honesty and accuracy**. A "No" response to any question will **not negatively impact the final accreditation decision**; rather, it will serve as a basis for guiding quality improvement efforts.

Before completing each section of the checklist, applicants are advised to **refer to the detailed accreditation standards provided in the brochure** for better understanding of the requirements.

Through this process, AFPI aims to support clinics on their journey toward continuous quality enhancement and excellence in primary care.

SELF ASSESSMENT FORM – AFPI ACCREDITATION FOR PRIMARY CARE CLINICS

(To be duly filled, scanned and sent by email to accreditation.afpi@gmail.com.

Please use capitals and blue/black pen only)

Section A: General Information

1. Clinic Name: _____
2. Clinic Address: _____
3. Contact Number: _____
4. Email ID: _____
5. Lead Doctor Name: _____
6. Lead Doctor Qualification: _____
7. AFPI Life Membership No.: _____
8. Medical Council Registration No.: _____
9. Operating Hours (days & timings): _____
10. Year of Establishment of clinic: _____

Section B: Mandatory Requirements

1. Is the clinic centred around primary care/general practice/family medicine
☐ Yes ☐ No
2. Valid license from local health authority:
☐ Yes ☐ No (Attach copy)
3. Licenses for additional services (whichever applicable):
 - Pharmacy ☐ Yes ☐ No (Attach copy)
 - Laboratory ☐ Yes ☐ No (Attach copy)
 - AERB licence for x ray/ ct scan ☐ Yes ☐ No (Attach copy)
 - PCPNDT licence for ultrasound ☐ Yes ☐ No (Attach copy)
 - MTP licence ☐ Yes ☐ No (Attach copy)
4. Display of State Medical Registration Certificate at clinic:
☐ Yes ☐ No (Attach copy)

Section C: Self-Assessment Against Accreditation Standards

1. Access to Care

- a) Clinic open ≥ 5 days/week ☐ Yes ☐ No
- b) Motorable access road throughout the year ☐ Yes ☐ No
- c) Building can be accessed by ambulance/ fire service ☐ Yes ☐ No
- d) Clear signage (including local language) ☐ Yes ☐ No
- e) Emergency contact number displayed ☐ Yes ☐ No
- f) Appointment booking system
 - ☐ Manual ☐ Digital ☐ Telephone ☐ Website/App ☐ None
- g) Services available, timings and doctors' details displayed on the premises
 - ☐ Yes ☐ No

2. Facility Management

- a) Minimum clinic area (≥ 250 sq. ft.): ☐ Yes ☐ No
- b) Fire safety equipment installed and maintained ☐ Yes ☐ No
- c) Oxygen cylinder storage compliance:
 - ☐ Valve and gauge fitted and in working condition
 - ☐ Cylinder kept upright
 - ☐ Cylinder kept in dry, well ventilated area
 - ☐ No flammable materials within 5 meters (16ft)
- d) Separate toilets for staff and patients ☐ Yes ☐ No
- e) Safe drinking water available ☐ Yes ☐ No
- f) Handwash facility with continuous water supply on every floor
 - ☐ Yes ☐ No
- g) Patient waiting/consultation areas clean, ventilated ☐ Yes ☐ No

h) Measures to ensure privacy

- ☐ Consultation chamber has a opaque door
- ☐ If no door, then Curtains / Room Separators available around the consultation cot
- ☐ No recording devices in patient examination areas
- ☐ Patient records accessed only by authorised individuals

i) Patient rights displayed ☐ Yes ☐ No

j) Patient satisfaction measured ☐ Yes ☐ No

k) Inventory of equipment/ supplies and consumables maintained and updated regularly ☐ Yes ☐ No (should be presented during inspection)

l) Inventory for pharmaceutical products (if applicable) ☐ Yes ☐ No (should be presented during inspection)

m) Expired stock checked and discarded periodically and relevant records maintained ☐ Yes ☐ No

n) Billing records maintained ☐ Yes ☐ No
(should be presented during inspection)

o) Patient Rights and Responsibilities displayed ☐ Yes ☐ No

p) Patient satisfaction assessment done periodically using questionnaire/ online survey/ feedback box ☐ Yes ☐ No

q) Clear process for quality improvement and escalation of issues to relevant persons exists ☐ Yes ☐ No

3. Environmental Sanitation & Water

- a) ☐ No open garbage dump, waste burning or exposed biomedical waste shall be within the clinic compound
☐ No open sewer, stagnant water within 50 mt of clinic compound
☐ No municipal landfills or large waste processing units within 500mt

If any of these points are not fulfilled, kindly mention the relevant mitigation measures undertaken for the same :

b) Daily General Waste disposal by:

☐ Municipal waste collection ☐ Private waste collection agents ☐ None

c) Waste Bins for general and biomedical waste covered and placed away from patient areas ☐ Yes ☐ No

d) Drainage and wastewater systems such as sewer pipes, manholes and septic tanks are sealed and free from leakage ☐ Yes ☐ No

e) Biomedical waste is segregated as per colour codes ☐ Yes ☐ No

f) Relevant signages present and staff is educated regarding segregation of biomedical waste ☐ Yes ☐ No

g) Biomedical waste disposal authority MOU/ certificate available

☐ Yes ☐ No (Kindly attach)

Name of authorised biomedical waste vendor

Date of MOU/ certificate _____

h) Water source to clinic

☐ Municipality water supply ☐ Borewell ☐ Private Tanker ☐ Other

i) Sump and Overhead tanks water tanks are covered, cleaned periodically

☐ Yes ☐ No

j) Water quality tested regularly ☐ Yes ☐ No (Not applicable for municipality water source)

4. Infection Control

- a) Daily cleaning of all floor surfaces with dry sweeping and mopping with disinfectant ☐ Yes ☐ No
- b) Daily cleaning of washrooms ☐ Yes ☐ No
- c) Regular sanitising of high-touch areas ☐ Yes ☐ No
- d) Hand Hygiene posters displayed ☐ Yes ☐ No
- e) Staff educated about hand hygiene ☐ Yes ☐ No
- f) Instruments sterilized properly ☐ Yes ☐ No
- g) Alcohol-based sanitizers accessible to patients, doctors and staff
☐ Yes ☐ No
- h) Personal protective gear such as gloves, masks and procedure gowns (if applicable) are available & accessible to all employees ☐ Yes ☐ No
- i) Fumigation of procedure rooms done periodically ☐ Yes ☐ No
- j) Notifiable diseases reporting done as per law ☐ Yes ☐ No

Notification done to which authority? _____

(any records maintained should be presented during inspection)

5. Safety & Security

- a) Fire NOC obtained (if required) ☐ Yes ☐ No
- b) Fire extinguishers checked annually ☐ Yes ☐ No
- c) Emergency exits clearly marked ☐ Yes ☐ No
- d) All patient access areas well lit and free from structural hazards
☐ Yes ☐ No
- e) Electrical wiring, earthing and insulation done as per building code
☐ Yes ☐ No
- f) All emergency contacts such as nearby police stations, fire station, ambulance services and nearby hospitals clearly displayed on the premises ☐ Yes ☐ No
- g) Clear written protocol for needle stick injuries available ☐ Yes ☐ No\

- h) Clear written protocol to handle blood and body fluid spills available
☐ Yes ☐ No
- i) Staff is aware of these occupational safety protocols and periodically reinforced ☐ Yes ☐ No

6. Human Resource Management

- a) Defined roles for staff ☐ Yes ☐ No
- b) Kindly mention name and qualification of staff who administer procedures/ injections to the patients
- | | |
|---------------|---------------------|
| 1. Name _____ | Qualification _____ |
| 2. Name _____ | Qualification _____ |
| 3. Name _____ | Qualification _____ |
| 4. Name _____ | Qualification _____ |
- c) All staff trained in Basic bystander CPR ☐ Yes ☐ No
- d) Periodic training to staff on safety, infection control, emergency protocols ☐ Yes ☐ No

7. Medical Records Management

- a) Records maintained are ☐ Physical ☐ Digital ☐ Both/Either
- b) Full name, Age, Gender, Phone number recorded for every consultation
☐ Yes ☐ No
- c) Prescription copies retained (either physical carbon copy or digital records) ☐ Yes ☐ No
- d) Records maintained ≥ 3 years (routine OPD), ≥ 10 years (MLC) ☐ Yes
☐ No
- e) Confidentiality maintained (locks/passwords/encryption) ☐ Yes ☐ No
- f) Old Records disposed securely ☐ Yes ☐ No

8. Emergency management

- a) Written protocols maintained for 10 common emergencies (refer brochure) that might be encountered at a primary care clinic
☐ Yes ☐ No
 - b) Nearby hospital contact info and addresses for prompt referral are displayed at the premises ☐ Yes ☐ No
 - c) Contact information of Ambulance services are available handy for prompt referral ☐ Yes ☐ No
 - d) Staff has been trained in basic bystander CPR ☐ Yes ☐ No
 - e) Basic emergency equipment (refer brochure) is available, checked regularly and kept in working condition ☐ Yes ☐ No
 - f) AED available (if high-volume clinic) ☐ Yes ☐ No
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Section D: Declaration

I, Dr. _____ (Applicant), hereby declare that the above information is true and correct to the best of my knowledge. All supporting documents have been attached where applicable.

Signature & Seal of Clinic

Date: ____ / ____ / ____

