**Information Sheet for District Hospital**

 **(To be collected at the time of visit)**

**General Information**

1. District \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Name of the Facility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Date of Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Visited By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Address (with any landmark): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Nearby referral Units\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Distance of the Facility from the nearest referral unit (in Km)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Type of building a) Government building b) Rented
9. Total number of beds \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. Proportion of rural and urban population a) Rural \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_b) Urban\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. Catchment population i.e. from which areas people usually come for care at this facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
12. Names of the “care seeking points for neonatal and child illness” under the Facility area :
13. Government \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
14. Private\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
15. Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
16. Is there a SNCU/NBCC available (detail in the facility observation checklist)
17. Area and infrastructure and human resource available for KMC unit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health statistics (for the most recent year)**

|  |  |  |
| --- | --- | --- |
| **Health indicators** | **Data** | **Source** |
| Birth rate |  |  |
| ANC coverage rate |  |  |
| Institutional delivery rate |  |  |
| Low birth weight rate |  |  |
| Neonatal mortality rate |  |  |
| Infant mortality rate |  |  |
| Under-five mortality rate |  |  |

|  |
| --- |
| **Contact number of key person(s) in the Facility** |
| **Key contact person** | **Designation** | **Phone number** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

* Photos of the Facility (from exterior and interior as well)
* Any miscellaneous information of probable use to the study, that comes up during the discussions with CS / Paedetician / Health Staff etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Checklist for health facility for care of low birth weight babies**

Name of the Health Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **General information**

|  |  |
| --- | --- |
| **Delivery practices** | **Response(s)** |
| Number of deliveries per month |   |
| Number of LBW/preterm babies born in the facility per month |   |
| Number of LBW/preterm babies referred to the facility per month |   |
| Number of LBW/preterm babies referred from the facility per month |   |
| Common reasons for referral of the LBW babies from the health facility |   |
| Common places of referral |   |
| **Infrastructure and Logistics** |
| Availability of SNCUs/ NBSUs |   |
| Number of beds in SNCUs/NBSUs |   |
| Practices of Baby Friendly Hospital Initiative followed? |   |
| Hospital Policies |
| What are the discharge guidelines for low birth weight babies |   |
| Presence of protocols and standards for management of LBW/preterm babies |   |
| **Training Status** |
| **Staff Nurses** | **SBA** | **FBNC** | **NSSK** | **Observership** | **FIMNCI** | **Any other please specify** |
| **LR / OT (Total / Trained)** |  |  |  |  |  |  |
| **SNCU / NBSU (Total / Trained)** |  |  |  |  |  |  |

1. **Equipments**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Essential Requirement(s)** | **Availability** | **Provision for Maintenance** | **Maintenance schedule** | **Remarks** |
| **Yes** | **No** | **Yes** | **No** |
| Radiant warmer |  |  |  |  |  |  |
| Reusable mucus suction trap |  |  |  |  |  |  |
| Mobile or fixed Resuscitation unit |  |  |  |  |  |  |
| Weighing scale |  |  |  |  |  |  |
| Thermometer |  |  |  |  |  |  |
| Suction machine |  |  |  |  |  |  |
| Self inflating bag and mask-neonatal size |  |  |  |  |  |  |
| Phototherapy unit |  |  |  |  |  |  |
| Incubators |  |  |  |  |  |  |

1. **Human Resources**

|  |  |  |
| --- | --- | --- |
| **Manpower** | **Existing number(s)** | **Qualification(s)/Training** |
| Paediatrician |  |  |
| Medical officer |  |  |
| Nurse-midwife(staff nurse) |  |  |
| Laboratory Technician |  |  |
| Health Educator |  |  |
| Radiographer |  |  |
| Ward boys/ nursing orderly |  |  |
| Dietician |  |  |
| Driver |  |  |

**To be filled by facility health staff by their own (Including MO / Staff Nurses / Nursing Sister/ Any other care provider involved in the New Born Care in the facility**

**( LR / OT / SNCU staff )**

1. **Experience and skill of the staff in care of low birth weight baby**
* **Name of the candidate** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Name of the Health facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Instructions:*** The checklist is meant to serve as a general guideline to assess the level of your skills within your speciality. Please use the scale below to describe your **experience/expertise** in areas listed below.

 **1**= Never performed **2**= Limited experience **3**= Comfortable performing **4**= proficient

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Care of low birth weight babies** | 1 | 2 | 3 | 4 | Not Applicable  |
| Experience in managing Low birth Weight (LBW) babies |  |  |  |  |  |
| Experience in promoting Kangaroo Mother Care (KMC) |  |  |  |  |  |
| Experience in managing baby with ARI especially pneumonia |  |  |  |  |  |
| Experience in managing baby with diarrhoea and dehydration |  |  |  |  |  |
| APGAR scoring |  |  |  |  |  |
| Breast feeding teaching |  |  |  |  |  |
| Parent teaching about healthy neonatal care practices (Thermal care/cord care/baby handling etc.) |  |  |  |  |  |

1. **Experience and skill of the staff in care of low birth weight baby**
* **Name of the candidate** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Name of the Health facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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* **Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Name of the Health facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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1. **Transport**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Availability of transport** | **Type of transport** | **Is it available 24\*7** | **Any concession for SC/ST and BPL card holders** | **Helpline Number** | **Remarks** |
|  **Yes** **No** | 1.2.3. |  |  |  |  |

1. **Basic support services**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Is the supply 24\*7** | **Is a complaint box available** | **Is the troubleshooting mechanism in place?** | **Remarks** |
| **Yes** | **No** | **Yes** | **No** | **Yes** | **No** |
| **Water supply** |  |  |  |  |  |  |  |
| **Electricity supply** |  |  |  |  |  |  |  |

1. **Kangaroo Mother Care Unit**
* **Is there a KMC unit already available –**
1. **YES**
2. **NO**
* **Availability of a separate space for KMC ward**
1. **Yes**
2. **NO**
* **If there is an availability of space for KMC, the size of the space\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Please attach site map of the facility indicating available & planned amenities for KMC unit.**

**Additional Comments on Facility If any:**