|  |  |
| --- | --- |
| ***Name of Facility*** |  |
| ***In Facility Information*** |
| ***Total No. Of Deliveries / Total No. of LBW (<2000 gm)*** | ***SNCU Unit (<2000 gm)*** | ***KMC Unit*** |
|  |
| ***Labor Room*** | ***OT*** | ***Total Admission*** | ***In Born Admission*** | ***Out Born Admission*** | ***Discharge*** | ***LAMA*** | ***Referred Out*** | ***Shifted to KMC Unit*** | ***Total No. Of babies*** | ***New Admission*** | ***Discharge*** | ***LAMA*** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |

***Form 4B : Observation Checklist cum Data Sheet for Implementation Support Team (To be Filled Weekly & Monthly)***

|  |  |  |  |
| --- | --- | --- | --- |
| **No. of Observations made at KMC Unit / Day (Average)** | **No. of Mothers Observed / Day (Average)** | **No. of Mothers Interviewed / Day (Average)** | **Number of times KMC Staff Nurse Available (Every observation) / Total observations** |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
|  | **Yes / No** | **Reason / Remarks** |
| **KMC Monitoring Formats Filled by Staff Nurses****(If No Reason)** |  |  |
| **Hygiene****(Cleanliness of toilets, floor, bed sheets changed)****If no, Specify reason** |  |  |
| **Hand Sanitizer available on Bedside (If no for how many mothers available)****If no, Specify reason** |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Counselling*** | ***No. of Mothers Counselled / Total No. of Mothers*** | ***Given By*** | ***No. of Mothers*** | ***Average Duration of Counselling (In Min.)*** |
| ***Counselling of Newly admitted Mother*** |  | ***Staff Nurse*** |  |  |
| ***Doctor*** |  |
| ***Routine Daily Counselling*** |  | ***Staff Nurse*** |  |  |
| ***Doctor*** |  |
| ***Counselling of Mother at the Time of Discharge*** |  | ***Staff Nurse*** |  |  |
| ***Doctor*** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Total No. of Fathers Counselled*** | ***Counselling Given By*** | ***Total No. of Family members Counselled*** | ***Average No. of family members counselled / Mother*** | ***Counselling Given By*** |
|  | ***Staff Nurse*** |  |  |  | ***Staff Nurse*** |  |
| ***Doctor*** |  | ***Doctor*** |  |

\* At least 1 Family member from a Family who is involved in care of New Born & Mother

|  |  |  |
| --- | --- | --- |
|  | ***7 AM – 7 PM*** | ***7 PM – 7AM*** |
| ***Duration of SSC Mean(SD)******Minimum – Maximum*** |  |  |
| ***Proportion of babies Exclusively Breast Feed (n;%)*** |  |  |
| ***Out of those EBF, mean no of times breastfeed (Mean/ SD/ Range)*** |  |  |
| ***Out of those on top feeds mean no of times breast feed(mean/ SD/ Range)*** |  |  |
| ***Specify type of top feed given to baby*** |  |  |

|  |
| --- |
| **Post Facility Information** |
| ***Visits by Study team from day of discharge*** | ***Number of Mothers Visited / due for visit by Study team*** | ***Number of Mothers counselled & supported by ASHA (as reported or observed) / due for counselling*** | ***Average Duration of Counselling (In Minutes:******as reported or observed)***  | ***Additional comments on the Quality of counselling*** |
| ***1st day of Discharge***  |  |  |  |  |
| ***2nd day of Discharge*** |  |  |  |  |
| ***3rd day of Discharge***  |  |  |  |  |
| ***6th day of Discharge***  |  |  |  |  |
| ***14th day of Discharge***  |  |  |  |  |
| ***21st day of Discharge***  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| ***Number of Mothers Visited by ASHA / due for visit (As per HBPNC Schedule)*** | ***Reason if ASHA didn’t visit*** | ***Number of Mothers Visited by ASHA / due for visit (Additional to HBPNC Schedule)*** | ***Reason if ASHA didn’t visit*** |
|  |  |  |  |

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| --- |
| **Additional Information / Key Points** |
|  |

|  |  |  |
| --- | --- | --- |
| **Issues** | **Action Taken** | **Outcome** |
|  |  |  |