**Supportive Supervision Checklist on Family Planning and Post Abortion Care in Health Facilities**

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| --- |
| **Health Center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Supervision: \_\_\_\_/\_\_\_\_/\_\_\_\_**  **District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Person conducting Supervision:\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Joint Supervision with the MoH? ( Yes / No)**  **Time Supervision Started: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time Supervision Ended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ***Instructions:*** *This tool is meant to aid supervisors in FP and PAC Supportive Supervision visits to facilities. Use the questions as a starting point for discussions with providers on areas which are going well and areas that need improvement. At the end of each section score the section, using the directions provided. Enter the findings into the training database after each visit.* |

**Section 1: FAMILY PLANNING SERVICES**

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| **FAMILY PLANNING SERVICES ENVIRONMENT**  ***Instructions:*** *Fill in this section by both asking a service provider at the facility and also making a direct observation to validate information.* | | | | |
| **Questions** | | | | **Yes = 1 No = 0** |
| 1 | Are child spacing/family planning services offered at this facility? | | |  |
| 2 | Are Family Planning procedures done in a private room? (With a door that can close and curtains on windows) | | |  |
| 3 | Is counseling of Family Planning clients done in a private room? (with a door that can close and curtains on windows) | | |  |
| 4 | Is there a seating area available for client/s in the room where they see a provider? | | |  |
| 5 | Is there a chair and table for health worker in the room where they see clients? | | |  |
| 6 | Adequate lighting available in procedure room? (for **both** day and night) | | |  |
| 7 | Sharps box within arm’s length of provider? | | |  |
| 8 | Is the area where Family Planning commodities are stored well organized? (FP stored by method in a clean area) | | |  |
| 9 | At your facility, is a skilled provider available 24 hours per day, 7 days per week for FP? | | |  |
| **SCORING**: Give 1 point for each **YES** response in this section  ---------  X 100 = …………..…%  9 | | | | |
|  | | | | |
| **AVAILABILITY OF FP COUNSELING MATERIALS**  ***Instructions:*** *Check to see whether these materials are visibly displayed in the FP room especially during client-provider counseling.* | | |
| **Questions** | | | **Yes = 1 No = 0** | |
| 1 | | Male Condoms? |  | |
| 2 | | Emergency Contraception Tablets? |  | |
| 3 | | Intra-uterine device (IUD)? |  | |
| 4 | | Injectables? |  | |
| 5 | | Implants? |  | |
| 6 | | Progesterone only pill (POP)? |  | |
| 7 | | Combined oral contraceptive (COC)? |  | |
| 8 | | IEC Materials on FP? |  | |
| 9 | | Family Planning Flipchart? |  | |
| 10 | | FP Wheel Card available? |  | |
| 11 | | FP Green Book available? |  | |
| **SCORING**: Give 1 point for each **YES** response in this section  ---------  X 100 = …………..…%  11 | | | | |

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| **AVAILABILITY OF FP COMMODITIES AND EQUIPMENT**  ***Instructions:*** *Check for the availability of the following commodities and equipment. Only check “YES” if you physically see the commodity/equipment.* | | | | |
| **Column 1: Commodities & Equipment** | | **Column 2: Available?** | | **Column 3: Adequate stock for 3 months?** | | **Column 4:**  **Any expired?** (no scoring of this section) |
|  | | **Yes = 1 No = 0** | | **Yes = 1 No = 0** | | **Yes or No** |
| 1 | Male Condoms |  | |  | |  |
| 2 | Intra-uterine Device (IUD) |  | |  | |  |
| 3 | Injectables |  | |  | |  |
| 4 | Implants - Jadelle |  | |  | |  |
| 5 | Implants - Implanon |  | |  | |  |
| 6 | Progesterone only pill (POP) |  | |  | |  |
| 7 | Combined Oral Contraceptive (COC) |  | |  | |  |
| 8 | Emergency Contraception Tablets |  | |  | |  |
| 9 | **Complete** equipment kit available for IUD insertion / removal  Note: **ALL** items must be present to check “Yes.” If any items are missing or not functional (rusting, etc) check “No” and circle items that need to be added or replaced |  | Graves Speculum (Med)  Uterine Tenaculum Sponge Forceps Dressing Forceps Uterine Sound Mayo Scissors Gallipot | | | |
| 10 | Postpartum IUD Insertion Forceps |  | 32 cm Curved Kelly post-partum forceps | | | |
| 11 | **Complete** equipment kit available for Implant Insertion / Removal  Note: **ALL** items must be present to check “Yes.” If any items are missing or not functional (rusting, etc) check “No” and circle items that need to be added or replaced |  | Mosquito Forceps (curved)  Mosquito Forceps (straight)  Scalpel, handle no. 3  Scalpel Blade  Trocar No.10 | | | |
| **SCORING**:  Part 1: Give 1 point for each **YES** answer for ‘Availability’ (Column 2): \_\_\_\_\_\_\_\_\_\_  Part 2: Give 1 point for each **YES** answer for ‘Adequate Stock for 3 months’ (Column 3): \_\_\_\_\_\_\_\_  Add the number of points from Part 1 & Part 2, and use as numerator (top number) in equation below:  ---------  X 100 = …………..…%  19 | | | | | | |
|  | | | | | | |
| **CLIENT EXIT INTERVIEW**  ***Instructions:*** *Interview 3 clients who received services for the first time today at the health facility. Introduce yourself and ask for permission to ask 6 questions. Do not pressure any client to answer the questions if they would rather not.* | | | | | | |
| Ask each client the following questions: | | **Client 1** | **Client 2** | | | **Client 3** |
|  | | **Yes = 1 No = 0** | **Yes = 1 No = 0** | | | **Yes = 1 No = 0** |
| 1 | Were you satisfied with the service provided and counseling session? |  |  | | |  |
| 2 | Did the provider answer all your questions to your satisfaction? |  |  | | |  |
| 3 | Does client understand how to use the method? |  |  | | |  |
| 4 | Did provider explain correctly what to do if there are problems side effects? |  |  | | |  |
| 5 | Did provider explain when to return to health center for follow-up? |  |  | | |  |
| 6 | Did the client feel that privacy was maintained during her interaction with the provider? |  |  | | |  |
| **SCORING**: Add all the YES scores in this section for all 3 clients. Insert this number in the blank spot as the numerator in the below calculation.  ---------  X 100 = …………..…%  18 | | | | | | |

**Section 2: POST-ABORTION CARE SERVICES**

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| **POST-ABORTION CARE SERVICES ENVIRONMENT**  ***Instructions:*** *Fill in this section by both asking a service provider at the facility and also making a direct observation to validate information.* | | | | |
| **Questions** | | | | | **Yes = 1 No = 0** | |
| 1 | Are PAC services offered at this facility? | | | |  | |
| 2 | At your facility, is a skilled provider available 24 hours per day, 7 days per week for PAC? | | | |  | |
| 3 | Are PAC procedure done in private room? (with a door that closes and curtains on windows) | | | |  | |
| 4 | Is adequate lighting available in procedure room? (both during the day and night) | | | |  | |
| 5 | Sharps box within arm’s length of provider? | | | |  | |
| 6 | Complete equipment kit available for PAC procedure?  (MVA and Misoprostol, per protocol of country) | | | |  | |
| **SCORING** : Give 1 point for each **YES** response in this section  ---------  X 100 = …………..…%  6 | | | | | | |
|  | | | | | | |
| **AVAILABILITY OF PAC COMMODITIES AND EQUIPMENT**  ***Instructions:*** *Check for the availability of the following commodities and equipment. Only check “YES” if you physically see the commodity/equipment.* | | | | | | | |
| **Column 1: Commodities & Equipment** | | | **Column 2: Available?** | **Column 3: Adequate stock for 3 months?** | | **Column 4:**  **Any Expired?** (no scoring of this section) | |
|  | | | **Yes = 1 No = 0** | **Yes = 1 No = 0** | | **Yes or No** | |
| 1 | | Misoprostol |  |  | |  | |
| 2 | | Antibiotics (For example: amoxicillin, ampicillin, ceftriaxone, ciprofloxacin, clindamycin, gentamycin, metronidazole) |  |  | |  | |
| 3 | | Analgesic (For example: Paracetamol, Ibuprofen, Tramadol) |  |  | |  | |
| 4 | | Anesthetics – (For example: Halothane, Ketamine, Lignocaine / Lidocaine 2% or 1%) |  |  | |  | |
| 5 | | **Complete** equipment kit available for MVA  Note: **ALL** items must be present to check “Yes.” If any items are missing or not functional, check “No” and circle items that need to be added or replaced |  | Vacuum Aspirators / Syringes  Silicone Lubricant (for O-Ring)  Adapters  Uterine Dilators, sizes 13-37  Flexible Cannulae, 4-12 mm | | | |
| **SCORING** :  Part 1: Give 1 point for each **YES** answer for ‘Availability’ (Column 2): \_\_\_\_\_\_\_\_\_\_  Part 2: Give 1 point for each **YES** answer for ‘Adequate Stock for 3 months’ (Column 3): \_\_\_\_\_\_\_\_  Add the number of points from Part 1 & Part 2, and use as numerator (top number) in equation below:    ---------  X 100 = …………..…%  9 | | | | | | | |

**Section 3: FP AND PAC DATA COLLECTION SYSTEMS**

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| **AVAILABILITY OF FP AND PAC DATA COLLECTION SYSTEMS**  ***Instructions:*** *Ask the providers to show you the following program tools. Do not count the tool as available unless you actually see the tool.* | |
| **Tool** | | **Available** |
|  | | **Yes = 1 No = 0** |
| 1 | FP Register |  |
| 2 | PAC Register |  |
| 3 | LARC Removal Log |  |
| 4 | FP Client Medical Cards – for facility filing |  |
| 5 | FP Client Follow Up Card – to take home with FP Client (short and long acting methods) |  |
| 6 | Copy of FP and PAC Program Monthly Facility Report – see last month |  |
| 7 | Stock Card/Inventory/Bin Card for FP (Should be at service point delivery in addition to pharmacy/dispensary of facility) |  |
| 8 | Copy of Consumption Report – see last month |  |
| 9 | FP Client Tracking and Archive System (Box or other) |  |
| 10 | Provider Procedure Logbooks for all trained Providers |  |
| **SCORING** : Give 1 point for each **YES** answer for this section:  ---------  X 100 = …………..…%  10 | | |

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| **FP AND PAC DATA MANAGEMENT**  ***Instructions:*** *Review all FP PAC Program tools (FP Register, PAC Register, FP Client Medical Card, FP Client Slip, Monthly Reporting Form and FP Client Tracking and Archive System)* | | | | | |
|  | | | | | | **Yes = 1 No = 0** | |
| 1 | | Is a weekly or monthly report prepared for the facility on Family Planning and PAC? | | | |  | |
| 2 | | Did they send a weekly or monthly FP and PAC report of the previous month (or week) to the district? | | | |  | |
| 3 | | Look at most recent Monthly or Weekly report: Was the facility copy of the report retained and stored away in an easily accessible place? | | | |  | |
| 4 | | Look at FP Register: Is the FP register up-to-date (Is most recent client information entered completely?) | | | |  | |
| 5 | | Look at PAC Register: Is the PAC register up-to-date (Is most recent client information entered completely?) | | | |  | |
| 6 | | Look at the LARC Removal Log: Is the most recent LARC removal client’s information entered completely? | | | |  | |
| 7 | | Look at Client Card: Are client cards up-to-date (Is client information from yesterday and today completely filled out)? | | | |  | |
| 8 | | Does the facility have a method (Client Box card filing system or other) to track FP continuation (e.g. do they know if a woman has not returned to pick up her re-supply of pills or her next injection)? | | | |  | |
| 9 | | Look at Client Cards in Client Tracking and Archive System Box: Is FP continuation information up-to-date? | | | |  | |
| **Request to see the FP Register.** Review the first ten case recordings on the day of visit or within previous one week. Use information from the register to complete the following table: | | | | | | | |
|  | | | 10 | 11 | 12 | | 13 |
| FP Method chosen or removed properly marked  **Yes = 1 No = 0** | Type of FP Client (new, returning, or postpartum) properly marked  **Yes = 1 No = 0** | Referrals documented on the register  **Yes = 1 No = 0** | | Assigned CHW properly documented  **Yes = 1 No = 0** |
| CASE 1 | | |  |  |  | |  |
| CASE 2 | | |  |  |  | |  |
| CASE 3 | | |  |  |  | |  |
| CASE 4 | | |  |  |  | |  |
| CASE 5 | | |  |  |  | |  |
| CASE 6 | | |  |  |  | |  |
| CASE 7 | | |  |  |  | |  |
| CASE 8 | | |  |  |  | |  |
| CASE 9 | | |  |  |  | |  |
| CASE 10 | | |  |  |  | |  |
| **Sum YES** | | |  |  |  | |  |
| If a question is “YES” 8 out of 10 times, consider this a “YES” answer for final score of this section. If it is less that 8 out of 10, it’s a “No” answer. | | | | | | | |
| **Final score (YES or NO)** | | |  |  |  | |  |
| **Request to see the PAC Register.** Review the first ten case recordings on the day of visit or within previous one week. Use information from the register to complete the following table: | | | | | | | |
|  | | | 14 | 15 | 16 | | 17 |
| Procedure performed is indicated in the register  **Yes = 1 No = 0** | Complications of abortion is indicated in the register  **Yes = 1 No = 0** | Referral action for PAC clients is indicated in the register if required  **Yes = 1 No = 0** | | Type of FP and/or FP counseling recorded in the register  **Yes = 1 No = 0** |
| CASE 1 | | |  |  |  | |  |
| CASE 2 | | |  |  |  | |  |
| CASE 3 | | |  |  |  | |  |
| CASE 4 | | |  |  |  | |  |
| CASE 5 | | |  |  |  | |  |
| CASE 6 | | |  |  |  | |  |
| CASE 7 | | |  |  |  | |  |
| CASE 8 | | |  |  |  | |  |
| CASE 9 | | |  |  |  | |  |
| CASE 10 | | |  |  |  | |  |
| **Sum YES** | | |  |  |  | |  |
| If a question is “YES” 8 out of 10 times, consider this a “YES” answer for final score of this section. If it is less that 8 out of 10, it’s a “No” answer. | | | | | | | |
| **Final score (YES or NO)** | | |  |  |  | |  |
| **Request to see the Delivery Register.** Review the first ten case recordings on the day of visit or within previous one week. Use information from the register to complete the following table: | | | | | | | |
|  | | | 18 | | 19 | | |
|  | | | Postpartum FP Counseling is indicated in the register  **Yes = 1 No = 0** | | If the woman delivering accepts an immediate form of post-partum FP, the type is indicated correctly in the register  **Yes = 1 No = 0** | | |
| CASE 1 | | |  | |  | | |
| CASE 2 | | |  | |  | | |
| CASE 3 | | |  | |  | | |
| CASE 4 | | |  | |  | | |
| CASE 5 | | |  | |  | | |
| CASE 6 | | |  | |  | | |
| CASE 7 | | |  | |  | | |
| CASE 8 | | |  | |  | | |
| CASE 9 | | |  | |  | | |
| CASE 10 | | |  | |  | | |
| **Sum YES** | | |  | |  | | |
| If a question is “YES” 8 out of 10 times, consider this a “YES” answer for final score of this section. If it is less that 8 out of 10, it’s a “No” answer. | | | | | | | |
| **Final score (YES or NO)** | | |  | |  | | |
| **Ask Provider to show you last the Monthly Facility Summary Report and compare to FP and PAC Register books:** | | | | | | **Yes = 1 No = 0** | |
| 20 | Is the total number of **NEW** FP clients recorded ***correctly*** from the FP Register to the Monthly Facility Summary Sheet? (Check for postpartum FP, PAC FP and all other FP clients separately, as outlined in Monthly Report) | | | | |  | |
| 21 | Correct tallying from PAC Register of PAC procedures provided in the month onto the Report? | | | | |  | |
| 22 | PAC Register indicates number of PAC clients counseled for FP for the month | | | | |  | |
| **SCORING**: Give 1 point for each **YES** answer for this section  ---------  X 100 = …………..…%  22 | | | | | | | |

|  |  |
| --- | --- |
| **FP AND PAC DATA USE – “USING DATA FOR ACTION”** | |
| **Yes = 1 No = 0** |
| 1 | Are up-to-date graphs showing the facility’s progress on FP displayed in the facility? |  |
| 2 | Can the facility staff explain the data trends in the graph? |  |
| 3 | Has the staff held a meeting to discuss their data in the last 3 months? |  |
| 4 | Can facility staff describe specific decisions taken or actions completed based on issues identified during their review of the data? |  |
| **SCORING**: Give 1 point for each **YES** answer for this section  ---------  X 100 = …………..…%  4 | | |

**Section 4: CLINICAL STAFF CAPACITY**

***Instructions:*** *This section counts clinical staff for the* ***entire*** *health facility, including other departments not related to FP, PAC, or Labor & Delivery. For “Other Clinical Staff” please indicate what level of clinical staff they are (eg. ‘clinical officer’)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CLINICAL STAFF TRAINED IN FP AND PAC** | | | | | |
| **1** | **2** | **3** | **4** | **5** | **6** |
| **Clinical Staff** | **Total # of Staff at post** | **Total # of Clinical Staff trained in**  **Long-acting FP Procedures** | **Total # of Clinical Staff trained in PAC Procedures** | **Total # of Clinical Staff trained in**  **PPIUD Insertion** | **# of Staff with FP PAC Procedure Logbooks up-to-date**  *(Only needed by those who are formally trained in FP PAC)* |
| Doctor |  |  |  |  |  |
| Nurse |  |  |  |  |  |
| Midwife |  |  |  |  |  |
| Other Clinical Staff |  |  |  |  |  |
| **SCORING**:   1. Write “1” point if 2-3 providers are trained in FP and available at this facility (see column 3 above) : \_\_\_\_\_\_\_\_\_ 2. Write “1” point if 2-3 providers are trained in PAC and available at this facility (see column 4 above): \_\_\_\_\_\_\_\_ 3. Write “1” point if 2-3 providers are trained in PPIUD and available at this facility (see column 5 above): \_\_\_\_\_\_\_\_ 4. Write “1” point if all of the staff who have been trained in FP and PAC have a FP PAC procedure logbooks up-to-date (see column 6 above): \_\_\_\_\_\_\_\_\_   Add the numbers reported in scoring instructions 1-4 above, and insert as numerator (top number) in calculation below:  ---------  X 100 = …………..…%  4 | | | | | |

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| --- | --- | --- |
| **CLIENT-PROVIDER CONSULTATION COUNSELING OBSERVATION**  **(QUALITY OF FP COUNSELING)**  ***Instructions:*** *Observe the FP counseling techniques for 2 different service providers. Through observation, indicate whether the following 10 criteria were met during the counseling session.*  *\*Be sure to ask client permission to be in the room during the counseling section, and let them know the information will be kept confidential.* | | |
|  | | **Client 1** | **Client 2** |
| **Yes = 1**  **No = 0** | **Yes = 1**  **No = 0** |
| 1 | **Did provider make sure of privacy in counseling?** *(no one else in room, counseling done in a private room)* |  |  |
| 2 | **Did the provider establish a cordial relationship with client and identifies her needs?**  *(Provider greets client, offers seat, proper self-introduction, confirms biographic information on client card, assures client of confidentiality and privacy)* |  |  |
| 3 | **Did the provider explain the benefit of child spacing for the mother, baby, and family and the recommended birth spacing interval?**  *(WHO recommended interval after a live birth before attempting the next pregnancy to be at least 24 months in order to reduce the risk of adverse maternal, perinatal and infant outcomes.)* |  |  |
| 4 | **Did the provider explore client’s knowledge of birth spacing and family planning and correct any misconceptions?** |  |  |
| 5 | **Did the provider demonstrate and explain all available contraceptive methods, including detailed information on LARCs?**  *(The demonstration should include physically showing the client what each FP method looks like)* |  |  |
| 6 | **Did the provider explore the clients interest in a method and helps her to arrive at the best method of her choice?** |  |  |
| 7 | **Did the provider ask the client about her medical history** (in order to think through appropriate screening criteria and medical eligibility criteria) **before commencing any method of choice?** |  |  |
| 8 | **Did the provider explain potential side effects of the method chosen and what to do if they occurred?** |  |  |
| 9 | **Did the provider give the client information on when to return for next appointment, and note this on FP Client Slip for client to take home?** |  |  |
| 10 | **Did the provider document the client discussion and findings on the FP register and FP Client Medical Card to stay at facility?** |  |  |

|  |  |  |
| --- | --- | --- |
| **No.** | **Name of Provider** | **# of ‘Yes’ answers above** |
| 1 |  |  |
| 2 |  |  |
| **SCORING**: Add the total ‘# of ‘Yes’ answers from the two providers observed above. Write this number as the numerator (top number) in the calculation below :  Score: ------------ X 100 = .........%  20 | | |

|  |  |
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| **SUPERVISION** | |
| **Questions** | | **Yes = 1 No = 0** |
| 1 | Did someone from DHS or the Supervision team visit this centre for supervision in FP and PAC supervision in last 3 months? |  |
| 2 | Did you receive constructive feedback from the last supervision experience at this facility? |  |
| 3 | Is last supervision report available?  Date: ……/……../………  Supervisor’s designation: ………. |  |
| 4 | Was there any progress of the last decision(s) which was taken during last visit? |  |
| **SCORING** : Give 1 point for each **YES** answer in this section  ---------  X 100 = …………..…%  4 | | |

**Section 5: INFECTION PREVENTION AND CONTROL**

|  |  |
| --- | --- |
| **INFECTION PREVENTION AND CONTROL IN FP AND PAC PROCEDURE ROOM** | |
| **Questions** | | **Yes = 1 No = 0** |
| 1 | Do they use disposable syringes during IM/IV injection? |  |
| 2 | Safety Precaution taken while giving injection?  *(wearing gloves, not recapping needles etc. )* |  |
| 3 | Water of alcohol hand rub for hand hygiene in the FP procedure room? Is hand-washing possible in procedure room?  *(disposable towels, individual towels, assisted hand washing procedure if no running water is available)* |  |
| 4 | Soap and/or disinfectant for washing hands? |  |
| 5 | Sharps box with cover? |  |
| 6 | Sterilizer/Autoclave available for FP equipment sterilization? |  |
| 7 | Proper waste disposal mechanism? (incinerator with fence, covered pit etc.) |  |
| **SCORING** : Give 1 point for each **YES** answer in this section  ---------  X 100 = …………..…%  7 | | |

**Section 6: SCORING**

|  |  |
| --- | --- |
| **Sub-Section Scoring:**  ***Instructions:*** *Write the scores from the different sections here. Add together all scores from section for the overall average score in the right-hand column.*  **Section 1: Family Planning Services Score**   * FP Services Environment \_\_\_\_\_\_\_\_\_\_\_\_% * FP Counseling Materials \_\_\_\_\_\_\_\_\_\_% * FP Commodities and Equipment \_\_\_\_\_\_\_\_\_\_% * FP Client Exit Interview \_\_\_\_\_\_\_\_\_\_\_\_%   **Section 2: PAC Services Score**   * PAC Services Environment \_\_\_\_\_\_\_\_\_\_\_\_% * PAC Commodities and Equipment \_\_\_\_\_\_\_\_\_%     **Section 3: FP and PAC Data Collection Systems**   * FP and PAC Data Collection Systems \_\_\_\_\_\_\_\_% * FP and PAC Data Management \_\_\_\_\_\_\_\_\_\_% * FP and PAC Data Use \_\_\_\_\_\_\_\_\_\_\_%   **­­­­­Section 4: Clinical Staff Capacity**   * Clinical Staff trained in FP and PAC \_\_\_\_\_\_\_\_\_\_% * Quality of FP Counseling \_\_\_\_\_\_\_\_\_\_\_% * Supervision \_\_\_\_\_\_\_\_\_\_%   **Section 5: Infection Prevention and Control** \_\_\_\_\_\_\_\_% | **Overall Section Scoring**  **Section 1 Score: \_\_\_\_\_\_\_%**  **Section 2 Score: \_\_\_\_\_\_\_%**  **Section 3 Score: \_\_\_\_\_\_\_%**  **Section 4 Score: \_\_\_\_\_\_\_%**  **Section 5 Score: \_\_\_\_\_\_\_%** |
| **OVERALL FACILITY SCORE:**  Instructions : Calculate the final score using the following calculation:  **Section 1 Score + Section 2 Score + Section 3 Score + Section 4 Score + Section 5 Score**  **5**  \*A quality child spacing and FP services is rated as scoring 80% or more.  \*All data should be entered into the Training Database after each visit. | **OVERALL FACILITY SCORE =**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%** |

**Section 7: Action Plan**

**Instructions:** List any problems or areas for improvement identified during the supervision visit. Use the why technique to identify the root cause of each problem. Then, write out specific, achievable action points that will result in provider or facility improvement. Be sure to include the person responsible, date to accomplish by, and a plan for follow-up.

| **Problems Identified** | **Root Causes Identified** | **Activities / Action points** | Person Responsible | Date Due | Were action points accomplished? |
| --- | --- | --- | --- | --- | --- |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |
| Signature of Supervisee:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Supervisor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: ........./........../............. Date: ........./........../.............  **DATE FOR NEXT SUPERVISION:**  ***Please leave a copy of signed report to respective facility before leaving and send one copy to district within 7 days of visit.*** | | | | | |