Ideal Clinic™ Manual

Version 19





1 April 2020

Updated April 2022

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP

FOREWORD

The purpose of a health facility is to promote health and to prevent illness and further complications through health promotion, early detection, treatment and appropriate referral. The success of South Africa's National Health Insurance will depend on a well functioning Primary Health Care (PHC) system. Community based services must be complimented by PHC facilities that will provide equitable access to South Africans, prioritising health services to those most in need. To achieve this, PHC should function optimally thus requiring a combination of elements to be present in order to render it IDEAL. To achieve this the National Department of Health started the Ideal Clinic programme.

An Ideal Clinic is a clinic with good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes and sufficient bulk supplies that use applicable clinical policies, protocols, guidelines to ensure the provision of quality health services to the community. An Ideal Clinic will cooperate with other government departments as well as with the private sector and non-governmental organisations to address the social determinants of health.

The Ideal Clinic programme defines ten components, 32 sub-components and 238 elements that must be green, which means that they are present and optimally functional. This Ideal Clinic realisation and maintenance manual has been developed to provide guidance on how to achieve Ideal Clinic status and to maintain such status. The manual is also a tool to assist progressive discipline.

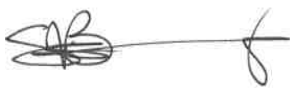
Jeanette Hunter led the initial development and completion of the first edition of the Ideal Clinic manual. Ms Ronel Steinhöbel updated the manual for the CHC framework, Version 1, which was reviewed by Mr Ramphelane Morewane, Mr Kgwiti Mahlako, Ms Maneo Dichaba and Dr Evangeline Shivambu.

My sincere gratitude to the National Department of Health programme managers, provincial department of health managers, district managers, PHC facility managers and non-govermental organisations who provided insightful comments and direction to the final draft.

I express special appreciation to Ronel Steinhöbel for taking the initiative to transform the checklists into score calculation tools and merging them as electronic tools into the monitoring and evaluation software. My special thanks to Dr Shaidah Asmall for meticulously providing the information for the checklists.

Version 19 of the Clinic framework and the manual is alligned with the Norms and Standards Regulations applicable to different categories of health establishments. In this regard, my special thanks to Dr Siphiwe Mndaweni, the Chief Excecutive Officer of the Office of Health Standards Complaince (OHSC) and the team of the OHSC, Ms Winnie Moleko, Dr Grace Labadarios and Mr Jabu Nkambule who worked with Dr Shaidah Asmall and Ms Ronel Steinhöbel to allign the Ideal Clinic elements with the Regualted norms and standards.

I sincerely thank the European Union(EU), the United States Agency for International Development (USAID) and Centers for Disease Control and Prevention (CDC) for their continued support of the Ideal Clinic programme.



Dr SSS Buthelezi
Director-General of Health
Date: 27.07.2020

TABLE OF CONTENTS

List of Annexures

LIST OF ACRONYMS

ANC	Antenatal Care
ART	Antiretroviral treatment
BANC	Basic Antenatal Care
BANC PLUS	Basic Antenatal Care Plus
CCMDD	Central Chronic Medicine Dispensing and Distribution
CHW	Community Health Worker
CoGTA	Cooperative Governance and Traditional Affairs
DCST	District Clinical Specialist Team
DHIS	District Health Information System
DHMT	District Health Management Team
DHS	District Health System
DoH	Department of Health
DPSA	Department of Public Service and Administration
DSP	District support partner
EML	Essential Medicine List
EMS	Emergency Medical Services
EPI	Expanded Program on Immunization
HAST	Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome, Sexually transmitted infections and Tuberculosis
HIV	Human Immunodeficiency Virus
HRH	Human Resource for Health
HTS	HIV testing service
ICSM	Integrated Clinical Services Management
IPC	Infection Prevention and Control
IQC	Independent Quality Control
JACCOL	Medical examination to detect: jaundice, anaemia, clubbing, cynanosis, oedema and lymphadenopathy
MCWH	Maternal Child Women's Health
Min / max	Minimum / maximum
MOU	Maternal Obstetric Unit
MRHS	Male Reproductive Health Services
NCD	Non-communicable diseases
NGO	Non-Governmental Organisation
NMC	Notifiable Medical Conditions
NHLS	National Health Laboratory Services
PACK	Practical Approach to Care Kit
PDoH	Provincial Department of Health
PEC	Patient Experience of Care
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PMDS	Performance Management and Development System
PNC	Prenatal Care

PPE	Personal protective equipment
PPTICRM	Perfect Permanent Team for Ideal Clinic Realisation and Maintenance
PSI	Patient Safety Incident
PT	Proficiency Testing
RTHC	Road to Health Chart
SANC	South African Nursing Council
SLA	Service Level Agreement
SOP	Standard Operating Procedure
TB	Tuberculosis
WBPHCOT	Ward Based Primary Health Care Outreach Team

INTRODUCTION AND BACKGROUND

The 'Ideal Clinic' (IC) programme is an initiative started by South Africa's National Department of Health (NDoH) in July 2013 as a way of systematically improving and correcting deficiencies in Primary Health Care (PHC) clinics in the public sector. These deficiencies were picked up by the NDoH facilities audit completed in 2012.

An Ideal Clinic is a clinic with good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes and adequate bulk supplies that use applicable clinical policies, protocols, guidelines as well as partner and stakeholder support, to ensure the provision of quality healthcare services to the community. An Ideal Clinic cooperates with other government departments as well as with the private sector and non-governmental organisations to address the social determinants of health.

Integrated Clinical Services Management (ICSM) is a key focus within an Ideal Clinic. ICSM is a health system strengthening model that builds on the strengths of the HIV programme to deliver integrated care to patients with chronic and/or acute diseases or who come for preventative services by taking a patient-centric view that encompasses the full value chain of continuum of care and support.

A standardised questionnaire which is translated into a framework (Ideal Clinic components, sub-components and elements) is used for tracking progress in PHCs over time. Since 2013 there has been substantial consultation on the framework. Feedback from health professionals and managers working at facility, district, provincial and national level improved the framework effecting changes from version 1 onwards. This version of the framework, version 19 is aligned to the Norms and Standards Regulations applicable to different categories of health establishments (2018).[1] The framework contains a subset of the measures for the Regulations. The framework consists of 10 components, 33 sub-components and 238 elements. See Annexure 1. Version 19 and thus this manual prescribe the minimum elements that should be present in a well-functioning clinic. See Annexure 2.

[1] Republic of South Africa. Norms and Standards Regulations applicable to different categories of health establishments. Pretoria: Government Gazette; Feb 2018.

Each element is scored according to the performance of the facility; green indicating that performance is achieved, amber indicating that the performance is partially achieved, and red indicating that performance is not achieved. The method of measurement (indicated with symbols), level of responsibility (facility, district, province or national) and weight (non-negotiable vital, vitals, essential and important) is indicated for each element. See Annexure 2.

The average score according to the weights assigned to the 238 elements determines whether Ideal Clinic status is achieved or not. The elements are weighted as Non-negotiable Vitals, Vital, Essential, and Important. In order for a facility to obtain an Ideal Clinic status the minimum average percentages for Non-negotiable Vitals, Vital, Essential and Important elements must be achieved as set out in Table 1. It is therefore important to note that a facility can obtain a high average score (70 to 99 percent) but still fail to obtain an Ideal Clinic category as they have failed to obtain the minimum average score for per weight category.

Weights	Silver	Gold	Platinum
Non-negotiable Vitals (3 elements)	100%	100%	100%
Vital (53 elements)	60-69%	70-79%	≥80%
Essential (104 elements)	50-59%	60-69%	≥70%
Important (78 elements)	50-59%	60-69%	≥70%

Table 1: Summary of Ideal Clinic categories

Over time, as the quality of the conditions of clinics improve, we may add more elements and more specifications for certain elements.

THE PURPOSE OF THIS MANUAL

The Ideal Clinic manual has been developed to assist managers at various levels of healthcare service provision to correctly interpret and understand the requirement for achieving the elements as depicted in the Ideal Clinic dashboard. It can therefore be regarded as a reference document which guides the managers to determine the status of Ideal Clinic dashboard elements in a facility. The manual is envisaged to be of particular use to the facility manager. Responsibility on the frameworks has been assigned to the facility manager in areas that the facility manager may believe is out of his/her control. However, for these areas it will be the facility manager who knows that the element is not green and it is the facility

manager who should initiate processes through the district office to turn these elements green.

The manual is also a useful tool for managers at sub-district, district, provincial and national level to ensure progressive discipline of those reporting to them. Facility managers must receive orientation to the IDEAL CLINIC REALISATION AND MAINTENANCE process using this manual. The content of the manual could then guide counseling sessions and further steps of discipline when weaknesses in clinics persist.

HOW TO USE THE MANUAL

The Ideal Clinic Manual is comprised of detailed steps that should be followed to achieve every element. In some instances, a step refers the reader to a specific annexure/s. This implies that the relevant annexure should be used for further guidance to achieve the element.

The annexures referred to in the steps is hyperlinked (highlighted in blue), therefore the reader can right click on the annexure name that is hyperlink in the step, then select *Open Hyperlink*. The reader will then be directed to the specific annexure (at the end of the document). If the reader wants to return to the steps, press *Alt* and the *Left arrow* keys simultaneously which will return the reader to the steps.

Documents, policies, guidelines and standard operating procedures referenced as being available on the National Department of Health's website (www.health.gov.za) can be obtained by selecting the 'Ideal Clinic' tab on the website. The tab will direct the user to the Ideal Clinic website (https://www.idealhealthfacility.org.za/). On the Ideal Clinic website there is a tab named 'Documents' where the relevant documents can be downloaded from.

COMPONENT 1: ADMINISTRATION

1. Signage and notices

Commitment for Ideal Clinic elements 1-3

Monitor whether there is communication about the facility and the services provided.

1	***All external signage in place***
2	***Facility information board displayed at the entrance of the premises reflects relevant information for the facility***
3	***Disclaimer sign is clearly sign posted at the entrance at the entrance of the facility***

Process

Step 1: Familiarise yourself with the requirements for external signs. See Annexure 3, Annexure 4 and Annexure 5.

Step 2: Do inspection every six months to check that all external signs for the facility are present and in good condition.

Step 3: In the event of having to replace new, damaged or missing signs, order signs from the sub-district/district manager through supply chain following the relevant provincial protocol.

Step 4: The signs will be installed either by the supplier or district maintenance staff depending on order specifications.

Note to reviewers:

- Facility information board must be on the wall next to the main entrance of the facility building OR on a free-standing board approximately 500 mm to 2000 mm before the main entrance to the facility building (entrance of the premises)
- It is not ideal but is acceptable if the information on the Facility information board is displayed on two separate boards (additional panel to main board) as the Ideal Clinic Programme did add additional information to the board since the first version was published.
- Emergency service contact numbers must include the contact numbers for ambulances and fire brigade.
- External signage must be formally manufactured signage.

Commitment for Ideal Clinic elements 4-7

Signs and notices are clearly placed throughout the facility.

4	***Vision, mission and values of the province/district are visibly displayed***
5	***Facility organogram with contact details of the facility manager is displayed on a central notice board***
6	***Patients' Rights Charter is displayed in all waiting areas in at least two local languages***
7	***All service areas within the facility are clearly signposted***

Process

Step 1: Ensure that the mission, vision and values of the district as well as the organogram with contact details of the managers are visibly displayed on a central notice board.

Step 2: Obtain the Patient's Rights Charter from www.health.gov.za.

Step 3: Visibly displayed Charter in all main waiting areas in at least two local languages. See Annexure 6.

Step 4: Conduct an inspection of the facility every six months to ensure that all internal signs for the facility are present and in a good condition. See Annexure 7.

Step 5: In the event of having to buy new or replace damaged or missing signs, order signs through supply chain management following the relevant provincial protocol.

Step 6: The signs will be installed either by the supplier or district maintenance staff.

Step 7: All notices like the vision, mission, values and organogram must be attached firmly to a notice board surface. Notices may only be attached to notice boards and to no other surface e.g. walls and windows.

Note to reviewers:

- Verify that organogram is up to date by comparing it with an updated list of the staff establishment of the facility.
- All internal signage must ideally be manufactured. Neatly typed and laminated signage is acceptable where the facility is still in the process of obtaining manufactured signage. Laminated signs must be in a good condition (it does not need to be framed). Hand written signs is not compliant.

2. Staff Identity and Dress Code

Commitment for Ideal Clinic elements 8 - 10

Monitor whether staff uniform, protective clothing and mode of staff identification are in accord to policy prescripts.

8	***There is a prescribed dress code for all service providers***
9	***All health care professional staff members comply with prescribed dress code***
10	***All staff members wear an identification tag***

Process

Step 1: Obtain the Staff Dress Code and Insignia specifications from the district. See Annexure 8 as an example of a Staff Dress Code.

Step 2: Share the contents of the Staff Dress Code with all staff members.

Step 3: All new staff must be inducted, including an orientation to the prescribed dress code.

Step 4: Compliance to dress code must be included in the staff performance agreements.

Step 5: Randomly check that the healthcare professional staff members on duty are dressed correctly according to the dress code. Check that all staff is wearing prescribed dress code (Annexure 9) and identification tags (Annexure 10).

3. PATIENT SERVICE ORGANISATION

Commitment for Ideal Clinic elements 11 - 13

The facility must be user friendly for the very sick, frail and elderly patients.

11	***Sign posted help desk/reception services are available***
12	***There is a process that prioritises the very sick, frail and elderly patients***
13	***A functional wheelchair is always available***

Process

Step 1: Schedule a monthly duty roster to assign staff to the help desk/reception. Ensure that the various languages spoken by staff at the facility are documented and available at the helpdesk/reception so that staff can be called to interpret when necessary.

Step 2: Develop a SOP that describes how the facility will ensure that the very sick, frail and elderly patients are prioritised.

Step 3: Display notice in at least two local languages in the waiting area indicating the prioritisation process for very sick, frail and elderly patients. See Annexure 11.

Step 4: Schedule in-service training for ALL staff on prioritisation process. Keep a record of attendance in the in-service training book. See Annexure 12 as an example.

Step 5: Delegate the function of prioritisation process to a designated staff member on a daily basis.

Step 6: Conduct random spot checks during the day to determine if the very sick, frail, and elderly patients are prioritised.

Step 7: Regularly check that the SOP and poster is available. See Annexure 13.

Step 8: Ensure that functional wheelchairs are available at the facility for use if and when needed.

Step 9: On a weekly basis, monitor the condition of the wheelchairs and order repairs if required

Step 10: If there are no functional wheelchairs available at the facility, order them using the standard provincial protocol.

Step 11: Schedule in-service training for all staff on safety procedures when transporting a patient in a wheelchair. Make a record of attendance in in-service training book. See Annexure 12 as an example.

4. Management of Patient Record

Commitment for Ideal Clinic elements 14 - 15

Every patient has a single record containing correctly captured personal and clinical information.

14	***There is a single patient record irrespective of health conditions***
15	***Patient record content adheres to ICSM prescripts***

Process

Step 1: All new patients will have a patient record opened for them using the National Adult or Child Record for Clinics and Community Health Centres.

Step 2: Allocate a file number using the Standard Operating Procedure for accessing, tracking, filing, archiving and disposal of patient records that has been approved for the province/district/.

Step 3: Every patient must have a single patient record that contains all clinical information including laboratory results, copies of referral letters and prescription charts as per ICSM prescripts. See Annexure 14

Commitment for Ideal Clinic elements 16 - 20

The patient records will be filed in a single location close to reception using a standard filing SOP to enable quick access of records.

16	***District/provincial SOP/guideline for filing, archiving and disposal of patient records is available***
17	***Guideline for filing, archiving and disposal of patient records is adhered to***
18	***There is a single location for storage of all active patient records***
19	***Patient records are filed in close proximity to patient registration desk***
20	***Retrieval of a patient's file takes less than ten minutes***

Process

Step 1: Obtain the provincial or district SOP for accessing, tracking, filing, archiving and disposal of patient's records.

Step 2: Verify that the content of the provincial or district SOP is aligned with the National Guideline for filing, archiving and disposal of patient record. See Annexure 15.

Step 3: Verify that the facility adheres to the SOP. See Annexure 16.

Step 4: Identify a secure and lockable storage area in or near reception for the filing of patient records.

Step 5: If needed, procure a bulk storage system according to the approved provincial protocol.

Step 6: Schedule in-service training for administrative staff on patient record filing, archiving and disposal procedures. Record attendance in the in-service training book/file. See Annexure 12 as an example.

Note to reviewers:

All SOPs must adhere to the following:

- ✓ Title of the SOP
- ✓ Name of the facility/district for which the SOP was developed
- ✓ Signed and dated by the accounting officer (District manager) OR facility must present written delegation if signing was delegated to someone else.
- ✓ Signed and dated by the compiler/chairperson that developed the SOP (recommended)
- ✓ Date of implementation
- ✓ Date of next review (SOPs must be reviewed at a minimum every 5 years)
- ✓ Summary of changes made to each version of the SOP (recommended)

Commitment for Ideal Clinic element 21 and element 22

Patients records are kept confidential at all times.

21	***Records are not left unattended in public areas and are only accessible to facility staff and patients***
22	***Records are not left unattended in clinical service areas***

Process

Step 1: Observe how patient records are managed in **various areas within the clinic**. Unauthorised individuals should not be able to access the information in the patient records. This will include the records of patients waiting to be seen, patients who have already been seen but their records have not yet been returned to the records storage area/room, patient records being used for clinical audit or other administrative purposes, or patient records outside the records storage area/room for any other reason. Such records should be kept in a manner which safeguards against unauthorised access to the content of the record.

Step 2: Observe how patient health records are managed in **consultation rooms and the medicine dispensary room**. Unauthorised individuals should not be able to access the information in the patient records. This will include the records of patient waiting to be seen and patients who have already been seen but their records have not yet been returned to the records storage area/room.

Commitment for Ideal Clinic element 23

Priority stationery for the facility is available at all times in sufficient quantities.

23	***Priority stationery (clinical and administrative) is available at the facility in sufficient quantities***

Process

Step 1: Determine the clinic specific minimum quantity for each item of stationery required.

Step 2: Using the stationery checklist (Annexure 17), the facility admin clerk must, on a weekly basis; check that there is sufficient stationery.

Step 3: Order the required quantity using the standard provincial procurement protocol.

Note to reviewers:

Check what the minimum levels are for the various stationery items (if the minimum levels for stationery has not been determined by the facility, the facility will be non-compliant to this element). Verify that the minimum required are present on the shelves. The facility will not be compliant if the minimum levels are not present. If the facility has already placed an order but the order has not arrived, yet the facility is non-compliant.

COMPONENT 2: INTEGRATED CLINICAL SERVICES MANAGEMENT (ICSM)

5: Clinical service provision

Commitment for Ideal Clinic elements 24

The facility has organised patient flow to provide patients with appropriate clinical care.

24	***Facility has been reorganised with designated consulting areas and staffing for acute, chronic health conditions and preventative health services***

Process

Step 1: Obtain the ICSM manual from www.health.gov.za.

Step 2: Determine the process flow in the facility. See process flow mapping in ICSM manual.

Step 3: Flow plan for facility must provide for an area for monitoring vital signs for the three streams of care.

Step 4: Schedule in-service training for all staff on the Integrated Clinical Services Management (ICSM). Record attendance in the in-service training register/book/file. See Annexure 18 as an example.

Step 5: Implement process flow as per plan.

Step 6: Mark out flow using colour coding to direct patients.

Name of Stream	Colour	Description of colour
Minor ailments	Orange	C0 M62 Y100 K0
Chronic Services	Blue	C77 M51 Y0 K0
Maternal and Child Health	Deep green	C63 M0 Y100 K0

Note to Reviewers:

Facilities that are too small (daily headcount of less than 170 patients per day (3 350 per month) to be segregated into three streams will not be expected to have dedicated consulting areas for acute, chronic health conditions and preventative health services but should still adhere to ICSM principles. This means that patients should be treated holistically and not be sent from one section to another because of co-morbidities. Small facilities that adhere to ICSM principles should be scored green for this element.

Commitment for Ideal Clinic element 25

Facility staff must ensure that patients' privacy is respected at all times in all service areas.

25 Patients are consulted, examined and counselled in privacy

Process

Step 1: The induction programme for new staff must include the importance of securing patients' privacy while being consulted or counseled.

Step 2: Patients should at all times be consulted and counseled behind closed doors/curtains/ screens.

Step 3: Do spot-checks to determine whether staff members respect patients' privacy while providing services and correct identified weaknesses.

Commitment for Ideal Clinic elements 26 - 30

Improvements in PHC service environment must lead to improved service and population health outputs and outcomes.

26	***TB treatment success rate is at least 87% or has increased by at least 5% from the previous year***
27	***TB (new pulmonary) defaulter rate < 5%***
28	***Ante-natal visit rate before 20 weeks gestation is at least 70% or has increased by at least 5% from the previous year***
29	***Ante-natal patients initiated on ART rate is at least 97% or has increased by at least 5% from the previous year***
30	***Immunisation coverage under one year (annualised) is at least 86% or has increased by at least 5% from the previous year***

Process

Step 1: The record-keeping process (data collection) in the facility must feed into the DHIS data or relevant electronic patient information system required to calculate the values of the above indicators.

Step 2: The record-keeping process (data collection) must be accurate, complete and validated to ensure good quality health management information.

Step 3: Calculate and analyse the data to determine whether the facility is achieving the above targets, see note below on how to conduct the status determination for elements 27 to 30.

Step 4: Should the clinic not reach the above targets, investigate to find reasons and implement corrective actions.

NOTE:

HOW TO CONDUCT THE STATUS DETERMINATION FOR ELEMENT 26

- If the facility obtained the target of 87% the facility scores green (achieved) for the element.
- If the facility did not obtain the target of 87%, there should be at least a 5% increase from the previous financial year:
  The TB programme use the calendar year (January to December) for reporting. The score for element 26 is determined by comparing the outcome of 1 year and 1 quarter ago with the outcome of 2 years and 1 quarter ago.

  For example:

If you conduct the status determination of a clinic on 10 November 2016 (4th quarter of the year) you compare the TB success rate of the 3rd quarter of 2015 with the TB success rate of the 3rd quarter of 2014. See table below for examples with values and scores.

Status determination conducted	TB success rate of 1 year and 1 quarter ago	TB success rate of 2 years and 1 quarter ago	Score
10 November 2016 = 4th quarter	3rd quarter 2015 = ≥87%		**Green**
10 November 2016 = 4th quarter	3rd quarter 2015 = 35%	3rd quarter 2014 = 30%	**Green**
10 November 2016 = 4th quarter	3rd quarter 2015 = 30%	3rd quarter 2014 = 33%	**Red**

HOW TO CONDUCT THE STATUS DETERMINATION FOR ELEMENT 27

The TB programme use the calendar year (January to December) for reporting. The score for element 27 is determined by looking at the TB defaulter rate of 6 months (2 quarters) back because the average TB patient is on treatment for 6 months.

For example:
If you conduct the status determination on 10 November 2016 (4th quarter) you look at the TB defaulter rate of the 1st quarter of 2016 (January to March 2016). See table below for examples with values and scores.

Status determination conducted	TB defaulter rate	Score
10 November 2016 = 4th quarter	1st quarter 2016 = <5%	**Green**
10 November 2016 = 4th quarter	1st quarter 2016 = ≥5%	**Red**

HOW TO CONDUCT THE STATUS DETERMINATION FOR ELEMENT 28 to 30

- If the facility obtained the target as described for the specific element the facility scores green (achieved) for the element.
- If the facility did not obtain the target as set, there should be at least a 5% increase from the previous financial year:
  a) When conducting the status determination during April to June (1st quarter) of a financial year, use the outcome of two financial years ago, comparing it with the outcome of three financial years ago if necessary.
  b) When conducting status determination during July to March (2nd to 4th quarter) of a financial year, use the outcome of the previous financial year, comparing it with the outcome of two financial years ago if necessary.

For example:

a) When conducting the status determination during April to June 2016, use the outcome of 2014/15 financial year and compare it with the outcome of 2013/14.
b) When conducting the status determination during July 2016 to March 2017, use the outcome of 2015/16 financial year and compare it with the outcome of 2014/15. See table below for examples with values and scores.

Status determination conducted	Outcome of indicator one or two financial years ago	Outcome of indicator two or three financial years ago	Score
10 July 2016	Outcome of 2015/16 = ≥ target set		**Green**
10 May 2016	Outcome of 2014/15 financial year = 40%	Outcome of 2013/14 financial year = 35%	**Green**
10 July 2016	Outcome of 2015/16 financial year = 50%	Outcome of 2014/15 financial year = 47%	**Red**

Note to reviewers:

If the facility does not provide the specific service mark not applicable.

Commitment for Ideal Clinic elements 31

Quality Improvement plans are developed and implemented

31 Quality Improvements plans are signed off by the facility manager and updated quarterly

Process

Step 1: Obtain the National Quality Improvement Guideline from www.health.gov.za that will assist facility managers to understand and implement quality improvements.

Step 2: Generate the "Quality Improvement Report" from the Ideal Clinic software once the first facility status determinations has been conducted at the end of May every year. See Annexure 19.

Step 3: Add any additional areas in need for improvement that has been identified in addition to the Ideal Clinic elements that were failed, for example, gaps identified in clinical audits, patient safety incidents, patient experience of care surveys, complaints, staff satisfaction surveys, security breaches, infection control risk assessment.

Step 4: Complete the columns for "Activity, By whom and When".

Step 5: The facility manager must meet with all staff to discuss the content of the draft quality improvement plan and to obtain inputs. Keep record of this meeting.

Step 6: Update the quality improvement plan with inputs received from staff.

Step 7: Facility manager to sign and date the quality improvement plan.

Step 8: Fill in at the end of every quarter the column for "Results" at each area where the "When" column was indicated for completion in that specific quarter.

Step 9: Use Annexure 20 to assess whether all areas were covered, and the plan has been updated at least quarterly.

Note to reviewers:

Facilities should only have one collated Quality Improvement Plan that is updated quarterly.

Commitment for Ideal Clinic elements 32

There is a functioning district/sub-district clinical leadership team that oversees clinical care and patient safety in facilities

32	***Six monthly district/sub-district clinical performance review report with action plan from clinical quality supervisors are available***

Process

Step 1: The district/sub district clinical quality supervisors compile a six monthly report on the performance of facilities in clinical areas. Obtain a template as an example of such a report on www.health.gov.za.

Step 2: The performance report must be tabled at the quarterly facility performance review meetings.

Step 3**:** The clinical performance report must be shared with ALL facilities in the district/sub-district to enable learning.

Step 4: The facility manager must table the report at the facility's quarterly staff meetings.

Note to reviewers:

Clinical quality supervisors can include but are not limited to District Specialist Clinical Teams and District Quality Assurance Units.

6. Access to Medical, Mental Health, Allied Health Practitioners

Commitment for Ideal Clinic elements 33 - 43

Access to a full range of health professionals to deliver a comprehensive health service either at the facility or through appropriate referral.

33	***Patients that require consultation with a medical practitioner have access to a medical practitioner at the facility at least once a week***
34	***Patients have access to oral health services***
35	***Patients have access to occupational therapy services***
36	***Patients have access to physiotherapy services***
37	***Patients have access to dietetic services***
38	***Patients have access to social work services***
39	***Patients have access to radiography services***
40	***Patients have access to ophthalmic service***
41	***Patients have access to mental health services***
42	***Patients have access to speech and hearing services***
43	***Staff dispensing medicine have access to the support of a pharmacist***

Process

Step 1: Map the facility's service provision against the approved PHC package of services.

Step 2: Document gaps differentiating between services to be provided on-site and those to be referred to other health facilities.

Step 3: Improve, in cooperation with sub-district/district manager, conditions at the facility (physical space, equipment, human resources, etc.) to initiate those services that are to be provided on-site.

Step 4: Describe in the facility's Standard Operating Procedure (SOP) for patient referrals the various referral paths (as mapped out in step 1) to be followed to allow access for patients to the services at other facilities that cannot be provided by the facility as described in elements 34 to 43. Make suitable

arrangements for patients that must be referred to other health facilities to receive the services that are not provided by the facility itself.

Step 5: Keep a register of the patients that are referred to other facilities. Refer to element 230 “There is a referral register that records referred patients”

Step 6: Ensure that the contact details of the pharmacy that is supporting the facility is available for healthcare professionals to enable them to contact the pharmacy if required.

Note to reviewers:

- To assess elements 34 to 42, check the District/Facility’s SOP for referral to other health facilities. The SOP must indicate the names and contact details of the health facilities where the patients will be referred to if the facility does not provide the services at the facility as set out in element 34 to 42. The contact details of the pharmacy that will give support to the facility must also be listed.
- Check that the register for referral of patients is available and completed. Where a facility had no referrals for the month the first line of the register must indicate “no referrals made for the month”.

Commitment for Ideal Clinic elements 44

Services to adolescents and youths are provided in a manner that promotes their health, prevents illness and support their development.

44 Adolescent and Youth Friendly Health Services are provided

Process

Step 1: Obtain the national policy for providing Adolescent and Youth Friendly Services (AYFS) from www.health.gov.za.

Step 2: Posters promoting AYFS that is in-line with the policy is visibly posted at the reception and in consulting room where AYFS is provided. See Annexure 21.

Step 3: Include training on AYFS for all healthcare professionals on the facility's staff development plan.

Step 4: Schedule in-service training for health professionals for providing adolescent and youth friendly services through the regional training centers. Record attendance in the in-service training book/file. See Annexure 12 as an example.

Step 5: Ensure that the Clinic Committee includes a representative of the adolescent and youth sector aged 18-24 years

Step 7: Complete the profile for adolescents and youth in the catchment area which includes their challenges, see Annexure 22.

Step 8: Verify that the facility provides adolescent friendly services, see Annexure 23.

7. Management of Patient Appointments

Commitment for Ideal Clinic elements 45 - 46

All planned streams of care are efficiently organised and properly managed through a proper patient appointment system for patients with stabilised chronic health conditions and MCWH patients.

45	***ICSM compliant patient appointment system for patients with chronic health conditions and MCWH patient is in use***
46	***Records of booked patients are retrieved not later than the day before the appointment***

Process

Step 1: Schedule in-service training for clinical and administration staff on the process to follow for patient appointment scheduling. See Annexure 24. This will be included in the ICSM training that staff should undergo. Record staff attendance in the in-service training register/book/file. See Annexure 12 as an example.

Step 2: Ensure communication and engagement with community to orientate all stakeholders about the clinic booking system.

Step 3: Assign appointment dates and times to patients.

Step 4: As per the patient appointment, the administration staff must retrieve patient records not later than the day before to the appointment.

Step 5: Administration clerk must retrieve patient record and tick off in the scheduling book that the record has been retrieved in the appropriate column. A cross should be made in red pen if the record is not found and measures must be taken to ensure that it is found before the patient arrives.

Step 6: Retrieve any outstanding results for laboratory investigations conducted during previous visits and place the results in the records.

Commitment for Ideal Clinic element 47

Clinically stable patients with chronic conditions are able to collect pre-dispensed medication.

47	***Pre-dispensed medication for clinically stable chronic patients is prepared for collection not later than the day before collection date or patients are enrolled on the CCMDD programme***

Definition of terms used in this section

Pre-dispense means the interpretation and evaluation of the prescription and the preparation and labelling of the prescribed medicine (Phases 1 and 2 of dispensing as defined in the Pharmacy Act, 1974 (Act 53 of 1974))

Process

If the facility does not have a CCMDD programme, follow the steps below:

Step 1: Refer to Annexure 25 on pre-dispensing of chronic medication.

Step 2: Use Annexure 26 (as an example) for recording receipt of chronic medication when delivered to a patient to their home by a Community Health Worker (CHW).

Note to reviewers:

If the facility does have a CCMDD programme follow the steps in the CCMDD Standard Operating Procedure.

8: Coordination of PHC Services

Commitment for Ideal Clinic element 48

PHC manager and staff will cooperate with schools and school health teams to assist with the removal of health-related barriers to learning.

48	***Facility does referrals to and receive referrals from school health services in its catchment area***

Process

Step 1: The facility manager and staff must be familiar with and have a relationship with all schools in the facilities' catchment area.

Step 2: Referrals from the school health team to the facility must be managed appropriately.

Step 3: Make provision for consulting learners referred from school health in the afternoons in line with the policy on adolescent friendly services.

Step 4: The school health team will refer learners on the prescribed form. Provide feedback to the school health team on the prescribed form. See Annexure 27.

Step 5: Keep record of learners that were referred and feedback that was provided. See Annexure 28 as an example.

Note to reviewers:

If the facility did not make or receive any referrals from school health services, the register/record as indicated in step 5 must indicate "no referrals received or made".

Commitment for Ideal Clinic element 49

The clinic must have functional home- and community-based services.

49	***Facility refers patients with chronic but stable health conditions to home- and community-based services for support***

Process

Step 1: With the support of the district manager ensure that a home- and community-based teams services the catchment population of the facility.

Step 2: Refer patients who need follow-up in their homes to the home- and community-based teams on the prescribed form. See Annexure 29 as an example.

Step 3: Keep record/register of patients referred to home- and community-based teams.

Step 4: Include the home- and community-based teams in the facility's quarterly meetings to receive feedback and to give guidance regarding possible challenges.

Step 5: Avail yourself to meet with home- and community-based teams on an ad hoc basis to assist with problems that arise during the course of work.

Note to reviewers:

If the facility did not make any referrals to home- and community-based services, the record/register as indicated in step 3 must indicate "no referrals made to home- and community-based services".

Commitment for Ideal Clinic element 50

Environmental health risks affecting the facility are attended to by environmental health services

50	***Facility refers environmental health related risks to environmental health services***

Process

Step 1: Obtain and record the contact details to report environmental health related risks to environmental health services in the facility's telephone list.

Step 2: Do frequent checks and report any environmental health related risk to the environmental health services as soon as it is noted, see Annexure 30.

Step 3: Follow-up with the district/sub-district office to assist if the reported risks have not been attended to.

Note to the reviewer:

The area to be assessed for the measures on Annexure 30 (Checklist for element 50) that relates to whether there are stagnant water, overgrown vegetation and litter on the outside perimeters of the facility is 100 meters from the perimeter fence/outside parameter,

9. Clinical Guidelines and protocols

Commitment for Ideal Clinic element 51 - 54

Ensure quality clinical care is delivered to patients by using relevant national clinical guidelines.

51	***ICSM compliant package of clinical guidelines is available in all consulting rooms***
52	***National guidelines on priority health conditions are available in the facility***
53	***80% of professional nurses have been fully trained on Adult Primary Care OR Practical Approach to Care Kit***
54	***80% of professional nurses have been fully trained on Integrated Management of Childhood illness***

Process

Step 1: Do an audit of consulting rooms to check availability of ICSM compliant package of clinic guidelines (soft OR hard copy OR Cell phone APP). Use Annexure 31.

Step 2: If all guidelines are not available, access from www.health.gov.za or order from Government Printing Works catalogue or download the APP.

Step 3: Do an audit to check availability of the National guidelines on priority health conditions (soft OR hard copy OR Cell phone APP). A copy of the guidelines must be available in one office that is accessible to healthcare professionals. Use Annexure 32.

Step 4: If all guidelines are not available, access from www.health.gov.za or order from Government Printing Works catalogue or download the APP.

Step 5: Identify an ICSM champion to be trained as a facility trainer by the district master trainers on the Adult Primary Care Guideline OR Practical Approach to Care Kit as well as on Integrated Management of Childhood illnesses.

Step 6: Schedule training for healthcare professionals quarterly on the Adult Primary Care OR Practical Approach to Care Kit as well as the Integrated Management of Childhood illnesses and keep attendance registers of the training conducted. See Annexure 12 as an example.

Note to reviewers:

For element 53: Staff must be trained on ALL the modules to be compliant.

For element 54: Staff member is fully trained if he/she has completed the four year nursing training that included IMCI training or has obtained a certificate for IMCI training course completed. The table below sets out the year in which IMCI training was incorporated into the four year nursing training for each province. Note: Facilities should have a list of employees indicating their qualification and year qualification obtained to assist inspectors to assess the measure.

Province	Current Nursing College name	Year of IMCI incorporation into the R425 programme	Level of study
Eastern Cape	Lilitha College of Nursing	2008	4th year
Free State	Free State School of Nursing	2006	2nd year
Gauteng	Gauteng College of Nursing	2004	1st, 3rd and 4th years
KZN	KwaZulu-Natal College of Nursing	2006	2nd year
Limpopo	Limpopo College of Nursing	2005	1st, 2nd, 3rd and 4th years
Mpumalanga	Mpumalanga College of Nursing	N/A	Mpumalanga did not incorporate IMCI into the R425 curriculum. Rather, **4th year students** are placed at RTC where IMCI programme is provided to the entire finalists before they are placed for Community Services. This is done immediately after they finish their final year examination.
Northern Cape	Henrietta Stockdale Nursing College	Not applicable	**4th year students are allocated two full weeks** and they are trained at the College with assistance of the Provincial Child health coordinator. Lecturers do the facilitation and if there is a need facilitators from districts do assist. Doctors are sourced from the Paediatric wards at the hospital
North West	North West Nursing College	2005	2nd year
Western Cape	Western Cape College of Nursing	2011	2nd year and 4th year
SA Military Service	South African Military Health Service Nursing College	2014	2nd year

Commitment for Ideal Clinic element 55 - 57

Nurses are able to resuscitate and provide basic life support to patients with a **sudden** onset of a condition manifesting itself by **acute** symptoms of **sufficient severity** such that the absence of immediate medical attention (including resuscitation) could reasonably be expected to result in serious impairment to bodily function or death.

55	***Resuscitation protocol is available***
56	***SOP for informed consent available***
57	***80% of professional nurses have been trained on Basic Life Support***

Process

Step 1: Check that the protocol on resuscitation is available at the facility.

Step 2: Check that the SOP for informed consent is available and that the content adheres to prescribe guidelines. See Annexure 33.

Step 3: Draft a schedule of nurses who have been trained on Basic Life Support by an accredited provider.

Step 4: Schedule training for nurses who have not been trained as well as for those who are due for their two-yearly updates in Basic Life Support.

Step 5: File a copy of the certificates obtained by the staff in Basic Life Support as proof that staff did complete it.

Step 6: Update register of nurses who have been trained or have updated their Basic Life Support certificate. See Annexure 34 as an example.

Commitment for Ideal Clinic element 58

Ensure quality clinical care is delivered to patients by using relevant national clinical guidelines

58	***50% of professional nurses at the facility are trained on* BANC Plus**

Process

Step 1: Schedule training for nurses who have not been trained on BANC Plus.

Step 2: Keep attendance registers of the training conducted. See Annexure 12 as examples.

Commitment for Ideal Clinic elements 59 - 62

The facility manages patient's safety incidents effectively to ensure that harm to patients is reduced.

59	***National Guideline for Patient Safety Incident Reporting and Learning is available***
60	***Facility/district SOP for Patient Safety Incident Reporting is available***
61	***Patient safety incident records comply with the National Guideline for Patient Safety Incident Reporting and Learning***
62	***All SAC 1 adverse events are reported to the next level of management within 24 hours***

Process

Step 1: Obtain the national Guideline for Patient Safety Incidents Reporting and Learning from www.health.gov.za.

Step 2: Develop a facility/district specific Standard Operating Procedure (SOP) using the National Guideline for Developing a Facility Specific SOP for Patient Safety Incidents Reporting and Learning.

Step 3: Check that the SOP is aligned to the national Guideline for Patient Safety Incidents Reporting and Learning. See Annexure 35.

Step 4: Assign a staff member to ensure compliance with the facility's SOP to manage Patient Safety Incidents.

Step 5: Follow the action steps to manage patient safety incidents as set out in the National Guideline.

Step 6: Report all SAC 1 incidents to the next level of management within 24 hours.

Step 7: Complete the Patient Safety Incident Management form when a patient safety incident occurs. See Annexure 36 as an example.

Step 8: Capture the information from the patient safety incident form on the national web-based information system for Patient Safety Incidents.

Step 9: If the facility did not have any patient safety incidents for a specific month, complete the 'Null Report' on the web-based information system.

Step 10: At the beginning of every month generate the following records for the previous month:

- patient safety incidents register. See Annexure 37.
- monthly statistics on patient safety incidents. See Annexure 38.
    - data on classifications of agents (contributing factors) involved
    - data on classifications of incident type
    - data on classifications of incident outcome
    - indicators for patient safety incidents

Step 11: Identify trends in system failures. To identify system failures analyse the data on classification of contributing factors and incident type to determine trends in cause/s of the incidents as well as frequently occurring incidents. Add to the facility's quality improvement plans areas where gaps in patient safety have been identified.

Step 12: Do quarterly checks to verify that the facility complies with the Guideline. See Annexure 39.

Note to reviewers:

- The Patient Safety Incident Management forms, forms for statistical data as well as registers do not need to be exactly in the same format/layout as set out in the National Guideline. The contents must however provide the data to enable the facility to report on the indicators and categories for patient safety incidents as set out in the National Guideline.
- For element 64, score NA if the facility did not report any patient safety incidents with SAC1 rating in the past 3 months.

Commitment for ideal clinic element 63 - 66

Quality clinical care is maintained by conducting regular clinical audits.

63	**National Clinical Audit guideline is available**
64	**Clinical audits are conducted quarterly on priority health conditions**
65	***80% of patient records audited are compliant***
66	**Clinical audit meetings are conducted quarterly in line with the guidelines**

Process

Step 1: Obtain National Clinical Audit guideline from www.health.gov.za.

Step 2: Obtain the National Clinical Audit Implementation Guideline for PHC facilities from www.health.gov.za. Note: Provinces that has approved Clinical audit guidelines should use their own guidelines which must align with the treatment guidelines for priority health conditions.

Step 3: Conduct quarterly clinical record audits on the files of patients diagnosed with priority health conditions that is in-line with the, Guideline. Verify that audits for each priority areas have been conducted. See Annexure 40.

Step 4: Use Annexure 41 to check whether 80% of the records that were audited for the priority health conditions are compliant according to defined measures

Step 5: Where there is a need, seek guidance of an expert from the district.

Step 6: Add to the facility's quality improvement plan areas identified for improvement.

Step 7: Provide feedback to relevant staff members.

Step 8: Implement improvements as per agreed time frame on the quality improvement plan.

Step 9: Discuss the facility's results of the clinical record audits on the quarterly Clinical audit meetings. Keep records of the meetings held.

Commitment for ideal clinic element 67

Notifiable medical conditions (NMC) are reported in-line with the national guidelines.

67 National guidelines are followed for all notifiable medical conditions

Process

Step 1: Ensure that all staff know the following in regard to NMC:

- why staff must report all NMCs
- Who should notify
- **NMC that falls within category 1 and 2 NMC, see Annexure 42**

Step 2: Report all category 1 NMCs immediately to the relevant focal person at the health establishment or Sub-District level using the most rapid means available.

Step 3: Obtain the SOP with flow chart, case definitions and case investigation forms from www.health.gov.za

Step 4: Obtain the NMC Notification booklet from the NMC focal person at Sub-District/District

Step 5: Report category 1 and 2 NMCs using the paper based or the electronic notification system:

Reporting can be done either via a paper based or an electronic notification.

Paper based notification

- Complete the NMC Case Notification Form which may be found on the NICD website.
- Send the NMC Case Notification Form to NMCsurveillanceReport@nicd.ac.za or fax to 086 639 1638 or send a photograph by sms, Whatsapp, email or fax to the NMC hotline 072 621 3805.
- Send a copy to the NMC focal person at Sub-District/District (details given on the NMC Notification booklet cover page).

- The NMC Focal Person at health facility level or Sub-District must ensure that the forms are captured electronically.

OR

Electronic notification via the NMC APP

Step 6: Verify that notifiable conditions are reported inline with the SOP for reporting notifiable conditions. See Annexure 43.

Note to reviewers:

- The facility must have the NMC Notification booklet OR have access to the web-based application to report NMC to be compliant
- Ask the staff member responsible for reporting NMC to explain:
  - the NMCs that must be reported (category 1 and 2 NMC) and
  - the process to be followed to report category 1 and 2 NMC

Commitment for Ideal Clinic element 68

Prevent and control infection

68 SOP for the management of patients with highly infectious diseases is available

Process

Step 1: Develop/obtain a facility/district specific Standard Operating Procedure (SOP) for the management of patients with highly infectious disease

Step 2: Verify that the content of the SOP covers the required topics. See Annexure 44.

Step 3: Staff to sign acknowledgment indicating that they are aware and know the content of the SOP and its application.

10. Infection Prevention and Control

Commitment for Ideal Clinic element 69 - 76

Prevent and control infection

69	*National **Infection Prevention and Control strategic framework is available***
70	***Facility has a designated staff member who is responsible for infection prevention and control***
71	***Standard Operating Procedure on infection control is available***
72	***All staff have received in-service training in the past two years on infection control standard precautions that is in line with the standard operating procedure.***
73	***Posters on hand hygiene is displayed***
74	***Awareness day on hand hygiene is held annually***
75	***Poster on cough etiquette is displayed in every waiting area***
76	***Staff wear appropriate protective clothing***

Process

Step 1: Assign a staff member to ensure compliance with the National IPC strategic framework. The staff member must be trained on infection prevention and control. This training can be provided by the district or the province, it does not need to be formal training provided by a specialised service provider.

Step 2: Obtain the National Infection Prevention and Control (IPC) strategic framework and the Practical Manual for the implementation of the National IPC strategic framework from www.health.gov.za.

Step 3: Use the Practical Manual for the implementation of the National IPC strategic framework as guidance to develop a district/facility specific SOP. Ensure that the key elements for standard precautions are addressed in the SOP as outlined in the national document. See Annexure 45.

Step 4: Schedule training for all staff on the infection control standard precautions, see Annexure 46. Repeat training every two years to ensure that staff is kept up to date. Keep attendance registers of the training conducted. See Annexure 12.

Step 5: Ensure that the poster on hand hygiene washing is displayed near the hand basins, see Annexure 47 and posters for alcohol based hand rub (ABHR) is displayed on the notice board (or wall where there is no notice board) in consulting areas, see Annexure 48. These posters should be laminated to avoid damage. A copy of the posters can be obtained from www.health.gov.za.

Step 6: Check that the posters are displayed. See Annexure 49.

Step 7: Plan and host an annual awareness day on hand hygiene to raise awareness with staff and patients. The awareness day can coincide with the Open day of the facility. The World Health organization's drives an annual hand wash campaign. Each year the *SAVE LIVES: Clean Your Hands* campaign of the WHO selects a specific topic for the year. Facilities can access the WHO's website (http://www.who.int/infection-prevention/campaigns/clean-hands/en/) to assist them in the planning of the awareness day as they publish promotional material every year in the form of pamphlets, posters and videos.

Activities can include but are not limited to:

- Signing up the facility in support of world hand hygiene on the WHO's website at http://www.who.int/gpsc/5may/register/en/
- Displaying posters on the annual theme in the facility
- Show health promotion videos on hand hygiene to staff and patients
- Host short information sessions for staff and patients on the importance of hand hygiene, method and opportunities for hand washing (5 moments for hand hygiene. Keep attendance registers of staff and patients that attended the sessions.

Step 7: Ensure that the poster on cough etiquette is displayed in every waiting area. See Annexure 50 as an example. A copy of the poster can be obtained from www.health.gov.za.

Step 8: Conduct spot checks to determine if staff are complying with personal protective clothing requirements. See Annexure 51.

Note to reviewers:

- Facilities must display both the poster for hygienic handwash technique and ABHR technique to be compliant with element 73.

Commitment for Ideal Clinic element 77 and 78

Prevent and control infection

77	***The linen in use is sufficient, clean, appropriately used and not torn***
78	***Dirty, soiled and infectious linen are collected in a wheeled cart or trolley***

Process

Step 1: Obtain the Practical Manual for the implementation of the National IPC strategic framework from www.health.gov.za that has a chapter on the management of linen.

Step 2: Orientate all staff on the use of clean linen, the appropriate use of all linen to ensure that linen is always used for its intended purpose and that linen that is torn must be replaced.

Step 3: Determine the stock levels required by a facility and comply with it.

Step 4: In large facilities dedicate a well ventilated room solely for storage of clean linen. In small facilities store linen on a clean and neat rack in store with other supplies and consumables or in a separate lockable cupboard.

Step 5: Keep linen store locked.

Step 6: Order linen as soon as the stock reaches a minimum level.

Step 7: Ensure that the facility has a trolley/cart to collect dirty, soiled and infectious linen.

Step 8: Use Annexure 52 to verify that linen is clean, appropriately used and not torn.

Commitment for Ideal Clinic elements 79

Prevent and control infection

79	*Sharps are disposed of in appropriately*

Process

Step 1: Train all staff including cleaning staff on the infection control standard precautions that included waste management (refer to SOP of element 71).

Step 2: Place waste segregation poster in a prominent position at all waste generation points. See Annexure 53.

Step 3: Ensure that there is enough stock of impenetrable, tamperproof containers to dispose of sharps.

Step 4: Ensure that all sharps containers are placed on work surfaces or placed in a wall mounted bracket while still in use.

Step 5: Store all sealed containers for sharps that had reached the limit mark in the designated area for storing healthcare waste.

Step 6: Designate specific waste storage areas that caters for the different types of waste without cross contamination. These areas must be lockable.

Step 7: Conduct regular spot checks at the facility's waste generation and waste storage areas to determine that correct waste handling and segregation is taking place.

Step 8: Use Annexure 54 to check that sharps are disposed of appropriately.

Commitment for Ideal Clinic elements 80

Risks are identified and attended to that can compromise infection control compliance

80	***An annual risk assessment for infection prevention and control compliance is undertaken by the staff member assigned to infection prevention and control***

Process

Step 1: Conduct an annual risk assessment for infection prevention and control compliance. Obtain the risk assessment tool from www.health.gov.za or use the risk assessment tool designed for the province/district/facility. Risk assessment can also be conducted by the provincial or district office.

Step 2: Analyse the results of the risk assessment.

Step 3: Add to the facility's quality improvement plan areas identified for improvement.

Step 4: Provide feedback to relevant staff members.

Step 5: Implement improvements as per agreed time frame on the quality improvement plan.

Step 6: Keep records of the collated summary of the results of the risk assessment.

Step 7: Discuss the facility's results for the risk assessment for infection prevention and control on one of the sub-district/district quarterly facility performance review meetings.

Commitment for Ideal Clinic elements 81

Prevent and control infection

81 All staff are made aware of the provincial letter/memo/circular that inform staff of the procedure to follow for prophylactic immunisations

Process

Step 1: Obtain a letter/memo/circular from the provincial head of health or the delegated staff member at the provincial office that inform staff of the procedure to follow for prophylactic immunisations. The letter should contain at a minimum the following information (see Annexure 55):

- Procedure to follow to obtain prophylactic immunisations
- Who will bear the cost of immunisations.
- Recommended vaccinations as determined by the disease profile of the health facility or region.

Step 2: Staff to sign acknowledgment indicating that they are aware and know the content of the letter/memo/circular and its application.

Note to reviewers:

- The letter/memo/circular from the provincial head of health or the delegated staff member at the provincial office must be reviewed at a minimum every five year or as the need arise.

11. Patient waiting time

Commitment for Ideal Clinic element 82 - 86

Patients are offered treatment in the quickest possible time.

82	***National Guideline for the Management of Waiting Times is available***
83	***National target of not more the three hours for time spent in a facility is visible displayed***
84	***Waiting time tools to record waiting time is available***
85	***Waiting time survey report is available***
86	***Average time that a patient spends in the facility is no longer than 3 hours***

Process

Step 1: Obtain the draft national guideline on waiting time from www.health.gov.za.

Step 2: Visibly display the national target of not more than three hours for time spend in a facility at the reception and waiting areas of the facility.

Step 3: Patients should be informed intermittently of any delays daily and mitigating measures that are being instituted.

Step 4: Waiting time must be monitored six monthly.

Step 5: The waiting time monitoring tool must be completed for every patient that were selected according to the sample size. File the tools for each survey.

Step 6: Capture the data from the monitoring tools on the Waiting Time module on www.idealhealthfacily.org.za or manually calculate the waiting time in each service area for every patient surveyed.

Step 7: Compile a report and compare the waiting time with the previous quarters to establish trends and need for improvement.

Step 8: If the facility's average time spend in the facility exceeds three hours, establish which service areas are causing the bottle-neck.

Step 9: Address deficiencies in bottle-neck areas.

Note to reviewers:

- To assess element 84: Request the waiting time survey forms used to record the waiting time for each patient. Assess whether the forms have been completed/filled.
- Step 5 and 6 will not be applicable for facilities that uses an automated electronic waiting time management system as the automated system will auto generate the completed monitoring tools. The records for the waiting time for each patient as recorded by the automated system must be available.

12. Patient Experience of Care

Commitment for Ideal Clinic elements 87 - 89

All patients are afforded the opportunity to voice their experience of care to guide service delivery improvement.

87	***National Patient Experience of Care Guideline is available***
88	***Results of the annual Patient Experience of Care Survey are visibly displayed at the main waiting area***
89	***An average overall score of 80% is obtained in the Patient Experience of Care Survey***

Process

Step 1: Obtain the National Patient Experience of Care (PEC) Guideline from www.health.gov.za.

Step 2: Conduct the survey as stipulated in the National PEC Guideline.

Step 3: Publish and display the results of the survey at the reception area. See Annexure 56.

Step 4: Develop the operational plan to respond to the results of the survey.

Step 5: Sign and date the commitment. See Annexure 57.

Step 6: Implement the quality improvement plan.

Commitment for Ideal Clinic elements 90-91

All patients will be afforded the opportunity to lodge a complaint, give a compliment or make a suggestion at the facility.

90	***National Guideline to Manage Complaints/Compliments/Suggestions is available***
91	***Complaints/compliments/suggestions toolkit is available at the main entrance/exit***

Process

Step 1: Obtain the National Guideline to manage complaints, compliments and suggestions from www.health.gov.za.

Step 2: Familiarise yourself with specifications for the complaints, compliment and suggestion box. See Annexure 58 for an example of the specifications.

Step 3: Order the box if there is not one available.

Step 4: Identify a visible and accessible location at the entrance and or exit of the facility for placement of the box. Install the box at the identified location.

Step 5: A pen and sufficient copies of the complaints, compliments and suggestions forms must be available from the person managing complaints, compliments and suggestions or next to the box. See Annexure 59.

Step 6: Obtain the National poster, See Annexure 60 that describes the process to follow when a patient wants to lodge a complaint, give a compliment or make a suggestion from www.health.gov.za.

Step 7: Visibly display the poster in at least two local languages at the main entrance/exit of the facility next to the complaints/compliments/suggestion box.

Step 8: Use Annexure 61 to check whether the complaints/compliments/suggestion toolkit is available.

Note to reviewers:

- If the forms and pen are not placed next to the box, a clear notice must be placed on or next to the box that directs patients and family/support persons to the helpdesk/reception to ask for a pen and or forms.
- It is not compulsory to use the National complaints, compliments and suggestion poster. The content of the poster must however contain the information as set out on the National poster.

Commitment for Ideal Clinic elements 92 and 93

Ensure that patient's complaints/compliments/suggestions are attended to within the prescribed time frame.

92	*The complaints/compliments/suggestions records compliance with the National Guideline to Manage Complaints/Compliments/Suggestions*
93	*Targets set for complaints indicators are met*

Process

Step 1: Develop a facility/district specific Standard Operating Procedure (SOP) using the National Guideline for Developing a Facility Specific SOP to Manage Complaints, Compliments and Suggestions.

Step 2: Assign a staff member to ensure compliance with the facility's SOP to manage complaints, compliments and suggestions.

Step 3: Follow the procedure to manage complaints/compliments/suggestions whenever complaints/compliments/suggestions are received.

Step 4: Capture the information from the complaints/compliment/suggestion form on the national web-based information system for Complaints/compliments/suggestions.

Step 5: If the facility did not have any complaints for a specific month, complete the 'Null Report' on the web-based information system.

Step 6: Keep the following records as stipulated in the National Guideline up to date:

- letters of complaint
- redress letters and/or minutes of redress meeting

Step 7: At the beginning of every month generate the following records for the previous month:

- complaints, compliment and suggestion registers. See Annexure 62.
- monthly statistical data on complaints, compliments and suggestions. See Annexure 63.

Step 8: Identify trends in system failures making use on statistical data on categories of complaints. Add to the facility's quality improvement plans areas where gaps have been identified.

Step 9: Do quarterly checks to verify that the facility complies with the guideline/SOP. See Annexure 64.

Step 10: Use Annexure 65 to check whether the targets set for complaints indicators were met.

Note to reviewers:

- The forms for statistical data as well as registers do not need to be exactly in the same format/layout as set out in the National Guideline. The contents must however provide the data to enable the facility to report on the indicators and categories for complaints, compliments and suggestions as set out in the National Guideline.
- Telephonic redress will be accepted as a form of redress if the user doesn't have a postal or e-mail addresses and are not able to come to the facility for a redress meeting. Date of telephonic redress must be noted down in the Complaints register. Users that cannot come to the facility for a redress meeting must be sent a letter via the post or e-mail as proof of redress conducted. Copy of letter/e-mail must be in the complaints file.

COMPONENT 3: MEDICINES, SUPPLIES AND LABORATORY SERVICES

13: Medicines and supplies

Commitment for Ideal Clinic element 94 to 95

Good Pharmacy Practice principles are followed for the management and administration of medicine

94	*There is a 'No unauthorised entry' sign on the door*
95	*SOP for the management of availability of medicines is available*

Process

Step 1: Ensure that there is a sign to indicate 'No unatrhorised entry' on the door of the medicine room/dispensary.

Step 2: Develop/obtain the SOP for the management and safe administration of medicines. An example of the SOP can also be obtained from www.health.gov.za

Step 3: Check that the content of the SOP is aligned with the requirements for the content of the SOP. See Annexure 66.

Step 4: Staff to sign acknowledgment indicating that they are aware and know the content of the SOP and its application. See Annexure 67.

Step 4: Staff must at all times follow the procedures as set out in the SOP when managing and administering medicines.

Note to reviewers:

The SOP for the management and safe administration of medicines can be a SOP developed by the facility or the district or the province. It is also acceptable if the facility has separate SOPs dealing with the management of medicine and the administration of medicine to patients.

Commitment for Ideal Clinic element 96 and 102

Ensure quality of medicine and hygiene in the medicine room is maintained through appropriate storage and temperature control.

96	***Hand hygiene facilities are available***
97	**Cleaning schedule for medicine room/dispensary is available**
98	**Cleaning is carried out in accordance with the schedule**
99	**All work completed is signed off by cleaners and verified by manager or delegated staff member**
100	**Medicine room/dispensary and waiting area are clean**
101	**Medicine room/dispensary is neat and medicines are stored to maintain quality**
102	***The temperature of the medicine room/dispensary is maintained within the safety range***

Definition of terms used in this section:

Dispensary is a room in a clinic where medicines are stored, and prescriptions are dispensed for patients attending the facility. In clinics where there is no dispensary, dispensing is done in the consulting room/s.

Medicine room is a room in a clinic where medicines are stored but no dispensing takes place.

Process

Step 1: Ensure the availability of liquid hand wash soap and disposable hand paper towels in the appropriate areas.

Step 2: Conduct daily inspections to ensure that hand hygiene facilities are available. See Annexure 68.

Step 3: Compile daily, weekly and monthly cleaning schedules for all areas in the facility. File in the designated file for cleanliness. See Annexure 69 as an example.

Step 4: Ensure that cleaning is in line with expected standards and that cleaners take responsibility for their allocated areas through appropriate supervision and sign-off on check lists for toilets. The manager or the professional health care staff member delegated by the manager to supervise the cleanliness of areas must also sign the checklist daily and indicate on the checklist whether he/she is satisfied with the cleanliness of the areas. The checklist must be filed in the cleanliness file and should be used to guide performance evaluation of cleaners. See Annexure 70 as an example.

Step 5: To check whether the cleaning is carried out in accordance with the schedule (element 97), check whether the cleaning checklist is aligned with the cleaning schedule (times and tasks on the schedule) and the work were signed off.

Step 5: Conduct daily inspections of the service areas of the facility using the Cleaning Inspection Checklist. See Annexure 71. If any areas are not clean, discuss with the relevant cleaner and get them to clean again.

Step 3: Medicines in the medicine room must be organised according to the system as stipulated in the facility/district/provincial SOP for the management and safe administration of medicines. See Annexure 72 as an example of how medicines can be organised in a medicine room. Do take note that this is only an example of how a medicine room can be organised, thus any other system will also be compliant.

Step 2: Ensure that the medicine room/dispensary is neat, and medicines are stored to maintain quality and availability at all times, see Annexure 73.

Step 3: Check availability and functioning of air conditioner in the medicine room/dispensary. If there is no air conditioner in medicine room/ dispensary, or the air conditioner is not in good working order, place an urgent procurement/works order for procurement/repair using the applicable procurement procedure.

Step 4: Mount the room thermometer on the wall in the medicine room/dispensary away from the direct flow of air from the air conditioner.

Step 5: Ensure availability of monthly temperature record charts to record the temperature of the medicine room, see Annexure 74.

Step 6: Allocate a staff member to record temperatures for the room daily using the temperature record charts.

Step 7: Maintain a file with all the completed monthly room temperature charts.

Step 8: Review the room temperature record chart weekly to ensure the temperature range for the medicine room/dispensary is within the safety range (below 25ºC) at all times.

Step 9: If the air conditioner is not working use a fan to keep the room cool.

Step 10: Use Annexure 75 to check whether the temperature of the medicine room/dispensary is maintained within the safety range

Note to reviewers:

- For element 101, for the measure "There is sufficient space in the dispensary/medicine room to store medicines needed in the facility":
  The criteria used to gauge whether there is sufficient space in the dispensary/medicine room to store medicines are that -
    - all medicines are stored in the medicine room and/or dispensary and not in sub-stores, passages or other areas in the facility; and
    - there is no medicine stored on the floor in the medicine room or dispensary
- For element 102: When conducting a status determination, check records for temperature control charts for the previous month.

Commitment for Ideal Clinic element 103

Ensure quality of medicine in the vaccine/medicine refrigerator is maintained through appropriate storage and temperature control.

103 Cold chain procedure for vaccines is maintained

Process

Step 1: Check availability and functioning of vaccine/medicine refrigerator for the storage of thermolabile medicines. If there is no vaccine/medicine refrigerator in medicine room/dispensary, or the vaccine/medicine refrigerator is not in good working order, place an urgent procurement/works order for procurement/repair using the applicable procurement procedure.

Step 2: For a medicine refrigerator, without a built-in temperature monitor and alarm system hang/place the refrigerator thermometer in the center of the fridge.

Step 3: Check that the fridge is not over full and that medicines and vaccines are packed appropriately in the refrigerator with enough space for air to circulate between containers, and that no stock is touching the back of the refrigerator/ condenser which could expose it to freezing.

Step 4: Ensure availability of monthly temperature record charts to record the vaccine/medicine refrigerator temperatures, see Annexure 76.

Step 5: Allocate a staff member to record temperatures for the vaccine/medicine refrigerator twice daily (at least seven hours apart) using the temperature record charts. In clinics which are not open every day of the week and do not have a monitoring device with an SMS alarm for out of range temperatures, check on temperature on departure and on arrival at the clinic.

Step 6: Check that there are no non-medicine items (such as food) kept in the refrigerator.

Step 7: Maintain a file with all the completed refrigerator temperature charts.

Step 8: Review the refrigerator temperature record chart daily to ensure the temperature range for the refrigerator is within the safety range (between 2 - 8ºC) at all times.

Step 9: Check that any out-of-range temperature recordings were immediately reported, have a dated signed-off record of corrective actions taken and that temperatures have remained within range thereafter. Temperatures below 0ºC may cause freezing and must also be corrected as this is critical to the viability of many vaccines.

Step 10: If refrigerator is not working follow contingency plan to ensure quality of medicines.

Step 11: Check availability of cooler box/es with suitable capacity, and ice packs for use in consultation rooms and in the case of emergencies.

Step 12: The cold chain for vaccines must be maintained at all times, see Annexure 77.

Note to reviewers:

When conducting a status determination, check records for temperature control charts for the previous month. If out of range temperatures were recorded during the previous month, confirm that corrective actions were taken and recorded.

Commitment for Ideal Clinic element 104

Ensure quality of medicine in the medicine cupboard or trolley is maintained through appropriate storage and temperature control.

104 Medicine cupboard or trolley is neat and orderly

Process

Step 1: Ensure that the medicine in the medicine cupboard or trolley is neat and orderly

Step 2: Ensure that medicine cupboard or trolley is locked when not in use

Step 3: Check daily that the medicine cupboard or trolley in the consultation room/s are neat and orderly. Use Annexure 78.

Commitment for Ideal Clinic element 105

Ensure quality of medicine is maintained through appropriate storage and temperature control.

105	***The register for schedule 5 and 6 medicine is completed correctly***
106	***Schedule 5 and 6 medicine in stock correspond with the balance recorded in the register***

Process

Step 1: Check that there is a SOP for the handling of schedule 5 and 6 medicines.

Step 2 Ensure that schedule 5 and 6 medicines are stored in a lockable cupboard and access to the keys is restricted.

Step 3 Check that there is a register to record the receipt and issuing of schedule 5 and 6 medicines (separate registers for schedule 5 and 6 medicines may be kept).

Step 4 Verify that all receipts of schedule 5 and 6 medicines are checked against invoices and entered in the register in accordance with the SOP.

Step 5 Record all issues of schedule 5 and 6 medicines to outpatients in the register in accordance with the SOP.

Step 6 Record the administration of schedule 5 and 6 medicines to patients in the facility in the register in accordance with the SOP. See Annexure 79 as an example of a register to record schedule 5 and 6 medicines.

Step 7 Check balances in the register weekly against physical stock.

Note to reviewers:

Verify that the receipt, issuing and administration of schedule 5 and 6 medicines are recorded in the register according to the guidelines as set out in the facility's SOP.

Commitment for Ideal Clinic element 107

Ensure consistent availability of essential PHC medicines.

107 Electronic networked system for monitoring the availability of medicines is used effectively

Process

Step 1: Apply to the district pharmacist for the installation of an electronic networked system for monitoring the availability of medicines

Step 2: Ensure that the SOP/Guideline for monitoring the availability of medicines is available.

Step 3: Staff responsible for managing the electronic networked system to sign acknowledgment indicating that they are aware and know the content of the SOP/Guideline and its application. See Annexure 67.

Step 4: Verify that the principles for managing and using the electronic networked system for monitoring the availability of medicines are adhered to, see Annexure 80.

Commitment for Ideal Clinic elements 108 and 100

Ensure consistent availability of essential PHC medicines.

108	***Stock take conducted in the medicine/dispensary in past 12 months***
109	***Medicines on the tracer medicine list are available***
110	***Re-ordering stock levels (min/max) are determined for each item on the district/facility formulary***

Definitions of terms used in this section:

Formulary

A formulary is a list of medicines extracted from the PHC Standard Treatment Guidelines and Essential Medicine List (PHC STGs/EML) approved for use by the Provincial/District Pharmaceutical and Therapeutics Committee (PTC) for a specific province/ district, category of facilities or even a single facility.

Essential medicine list

The South African PHC STGs/EML, see Annexure 81, provides a list of medicines, together with guidelines to support guiding rational medicine use. It provides a foundation for supporting preventative and curative healthcare services at primary healthcare level. Essential medicines are those that satisfy the priority healthcare needs of a population. They are selected with respect to disease prevalence and public health importance, with selection decisions made through the review of clinical evidence considering efficacy, safety, quality and comparative cost-effectiveness

Tracer medicines list

A tracer medicine list is a list of medicines which is extracted from the PHC STGs/EML, taking into account the most common morbidities and health needs within a particular setting. The list is used as a monitoring tool within PHC facilities as a proxy for measuring the availability of a basket of essential medicines within a particular setting. An electronic networked system can be used to monitor the availability of tracer medicines

Process

Step 1: The facility manager or nurse designated to manage medicine in the facility must:

- ensure that all medicines on the formulary (extracted from the PHC STGs/EDL) applicable to the facility are available;
- ensure all tracer medicines are monitored weekly, see Annexure 82;
- check the medicine room/dispensary, and medicine trolleys/cupboards to ensure stock is stored according to best practice following *First Expired First Out* (FEFO) stock rotation principles.

Step 2: Determine reorder levels for stock items as per SOP.

Step 3: Check stock in the medicine room and/or dispensary weekly to ensure stock levels are maintained within the minimum/maximum range for replenishment.

Step 4: For facilities with an electronic networked system for monitoring availability of medicine, report stock levels as per the approved schedule and standard operating procedure.

Step 5: Place a replenishment order to maintain medicine stock levels using the applicable SOP.

Step 6: If an order is not received in full or in accordance with the pre-determined schedule, follow up in writing and telephonically immediately with the supervising pharmacist and/or supplier of stock (depot, sub-depot or hospital).

Step 7: Follow local procedures if the stock is not delivered within seven days.

Step 8: Conduct an annual stock taking.

Commitment for Ideal Clinic element 111 - 114

Ensure that expired medicines are removed from the facility and disposed of safely, minimising the risk of harm to the environment and people.

111 There is no expired medicines on the shelves

112 Waste receptacles for pharmaceutical waste are available

113 Health care waste is managed appropriately

114 Expired medicine is disposed of according to prescribed procedures

Process

Step 1: Check the medicine room/dispensary, and medicine trolleys/cupboards to ensure that expired stock has been removed.

Step 2: Return medicines that will expire within three months or are unlikely to be used before expiry to the immediate supplier of stock or make arrangements for stock to be rotated to other facilities that could use the medicines before expiry.

Step 3: Record details of medicine that has expired before it is sent for destruction. See SOP for the management of availability of medicine at www.health.gov.za

Step 4: Maintain all records in a file.

Step 5: After recording, expired stock seal the expired medicine securely in an appropriate container as per SOP.

Step 6: Store all expired stock items separately from usable stock, in the waste receptacles in accordance with the applicable SOP.

Step 7: It is the responsibility of the pharmacist's assistant or professional nurse designated to manage medicine in the facility to ensure that expired medicine is removed from the facility.

Step 8: The supervising pharmacist must ensure that the expired medicine is disposed of in accordance with applicable legislation and supply chain procedures. See National SOP for the management of excess, short dated, obsolete, expired and unusable medicines.

Step 9: Check that waste is managed appropriately in the medicine room/dispensary. See Annexure 83.

Note to reviewers:

- Expired stock must be stored separately from stock which is being used for supply to patients. It may be stored separately in the appropriate waste receptacles in the medicine room, but not on the shelves of the dispensary.
- When conducting a status determination, ask the facility manager or nurse designated to manage medicine to explain the process to be followed at facility level for disposal of expired medicines. The element is scored green if he/she explains the process correctly.

Commitment for Ideal Clinic element 115

Manage minor injuries at Primary Health Care facilities.

115 Basic medical supplies (consumables) are available

Process

Step 1: Determine re-order levels for each item on the list for basic surgical supplies. Verify that all medical supplies are available, see Annexure 84.

Step 2: Monitor stock of basic surgical supplies weekly.

Step 3: Place a replenishment order to maintain the minimum/maximum surgical supply levels using the prescribed procurement procedure.

Step 4: If order was not received on schedule follow up immediately with district pharmacy.

14. Management of Laboratory Services

Commitment for Ideal Clinic element 116 – 120

The facility uses laboratory technology to ensure that patients' health conditions are managed appropriately.

116	***Primary Health Care Laboratory Handbook is available***
117	***Required functional diagnostic equipment and concurrent consumables for point of care testing are available***
118	***Required specimen collection materials and stationery are available***
119	***Specimens are collected, packaged, stored and prepared for transportation according to the Primary Health Care Laboratory Handbook***
120	***Laboratory results are received from the laboratory within the specified turnaround times***

Process

Step 1: Obtain the Primary Health Care Laboratory Handbook from www.health.gov.za.

Step 2: Where there is no electronic access, obtain hard copies from the sub-district or district manager.

Step 3: Ensure that all required functional diagnostic equipment and concurrent consumables for point of care testing are available. See Annexure 85.

Step 4: Ensure that required specimen collection materials and stationery are available. See Annexure 86.

Step 4: Induct all new staff on the NHLS process on handling specimens correctly as outlined in the manual. Conduct spot checks to make sure the process is being followed correctly. See Annexure 87.

Step 5: Using the manual or electronic tracking form check if patient laboratory results have been received within the specified time frame. See Annexure 88.

Step 6: If the results have not been received within the specified turnaround times, follow up with the laboratory.

Step 7: File/record all abnormal results appropriately in the patient record within 24 hours of receipt, all other results to be filed/recorded within 5 working days.

Commitment for Ideal Clinic element 121

Inter-facility comparison to determine if HIV testing services can provide correct test status

121 Facility is enrolled as testing point in the NHLS HIV- Proficiency Testing scheme

Process

Step 1: Ensure healthcare facility performing HIV testing service (HTS) is enrolled in HIV Serology Proficiency Testing (PT) scheme provided by the National Health Laboratory Service (NHLS).

Step 2: If the facility is not enrolled in the HIV Serology PT:

- For PEPFAR supported facilities, the facility should work with the district HAST Directorate and supporting district support partner (DSP) for the enrolment of the sites. PEPFAR is responsible for the cost for the enrolment.
- For facilities not supported by PEPFAR, the facility should work with the district HAST Directorate for the enrolment of the site and will be responsible for the cost of the enrolment.
- Application forms can be requested from NHLS. Application is done in the last three months of every year, once completed it must be sent to ptsadmin@nhls.ac.za.
- Cost for enrollment is more or less R600 per survey for 2018.

Step 3: Treat PT samples as potentially infectious and follow universal safety precautions at all times when handling them.

Step 4: Upon PT package reception at facility, wear personal protective equipment (PPE) e.g. gloves and Plastic aprons. Inspect the package for breakages, and deterioration or missing sample. The package should contain six samples. Broken samples should be disposed-of according to the health and safety protocols used in your facility. For missing samples, facilities must notify the NHLS PT schemes immediately so that replacement of samples can be issued.

Step 5: Carefully read the instruction sheet enclosed in the package and note the deadline for return of the PT testing results to NHLS.

Step 6: Store samples in fridge before use at 2˚C to 8˚C.

Step 7: All testers providing HTS must participate in proficiency testing. Ideally, each tester should be able to test all samples at a given PT survey, but to accommodate all

testers, it is recommended that two testers should participate in a PT survey at a time. Each tester, should tests three PT samples. The name of both testers should be written on the PT response form and details of the samples tested by each tester must be noted. All testers in the site should alternate participation in the subsequent survey.

Step 8: Use personal protective equipment (PPE) when testing PT samples.

Step 9: The samples must be tested with HIV test kits used for routine HTS and the national HIV testing algorithm must be followed. That is, confirmatory test should only be conducted when the screening test is reactive. Test 1 is the screening test and test 2 is the confirmatory test.

Step 10: After use, store the remaining samples in a deep freezer at -20˚C. This is because NHLS may require the sample to be re-tested. Used PT samples must be disposed-of after the score of the survey is issued by NHLS and received by the healthcare facility; and applicable corrective action is done and the corrective action report is complete. The samples should be disposed-of according to the health and safety protocols used in your facility.

Step 11: The PT form must be completed in full with the site IDENTIFICATION CODE and results of the testing twice a year in April/May and Oct/Nov. Record result of PT sample testing in the spaces provided in the PT response form corresponding to the sample number. The form without identification code will be rejected automatically as the healthcare facility that sends the form cannot be identified. The form can be sent to NHLS by email and fax. It is important to use only contacts details provided by NHLS on the response form which is included in the PT package.

Step 12: The facility manager must review the PT response form and sign it before it is sent to NHLS. A copy of the PT response form used to submit result of the testing must be kept in a file for PT at the healthcare facility. Confirm if NHLS PT schemes has received your PT form before the closing date for the submission.

Step 13: The facility manager must also review and sign the PT report from NHLS and share it with testers. The signed copy must be kept in the PT file at the healthcare facility. Corrective measures must be implemented according to the PT results indicated in the report. The corrective action implemented must be recorded and kept in the PT file.

Note to reviewers:

- Note that this element is only applicable for facilities that are enrolled for the HIV Serology Proficiency Testing (PT) scheme provided by the National Health Laboratory Service (NHLS). If the facility is not part of the pilot mark the element as not applicable.
- Check PT file of the facility for participation and performance in last PT survey (April/May and Oct/Nov), the facility is compliant if:
    - the response from was signed off by the facility manager before being sent to NHLS PT section
      AND
    - the PT report that contains the results of the last PT survey was signed off by the facility manager, showing that it has been reviewed by the manager. Scores of 80 – 100% is acceptable. For scores<80%, a record of planned or implemented corrective action must be available in the PT file.

Commitment for Ideal Clinic element 122

To assess performance of test kits prior to testing patients

122 Facility controls rapid test kit performances by running negative and positive control on a weekly basis

Process

Step 1: Ensure healthcare facility providing HIV testing service (HTS) is implementing Independent Quality Control (IQC) regularly to monitor quality of HIV rapid test kits.

Step 2: Treat IQC samples as potentially infectious, follow universal safety precautions at all times when handling them, and as per instructions enclosed in the IQC package.

Step 3: Ensure that sufficient stock is ordered from NHLS to avoid stock out of IQC samples. DO NOT USE IQC sample when expired or if suspected to be contaminated or showing signs of deterioration e.g. clumping, change of colour, turbidity or foul odour. IQC sample should be disposed-of when it is expired or contaminated. The health and safety protocols used in your facility should be followed to dispose-of the sample.

Step 4: Upon receiving new stock of IQC samples, they should be kept in a freezer at or below -20^{o}C until opened for use. Once thawed (defrosted) for use, they should be stored in the fridge at 2˚C to 8˚C. Ensure control sample tubes are recapped and sealed tightly and restored at 2-8^{o}C immediately after use.

Step 5: Perform IQC testing once a week at the minimum, preferably at the beginning of the week and/or on receiving a new shipment of test kit; at the beginning of a new lot number; and when environmental conditions exceed range needed for stability of the test kits e.g. high temperature.

Step 6: Use personal protective equipment (PPE) when testing IQC samples e.g. gloves and plastic aprons.

Step 7: Perform IQC testing with negative control and positive control on the screening test and confirmatory test respectively. Follow the serum testing procedure described for the screening test and confirmatory test in conducting the IQC testing.

Step 8: Follow the job aide for the screening and confirmatory test for interpretation of IQC testing results. A negative control testing should yield a non-reactive result for both the screening test and confirmatory test and a positive control a reactive result for both the screening test and confirmatory test.

Step 9: If IQC testing produces a false result, repeat the test and ensure that the test procedure described in the job aide or manufacturer package insert is accurately followed. If repeated test still produces a false result, it may indicate a problem with the test kit or control sample. Repeat the test using a new control sample. Also, for invalid IQC test, repeat the test. Check the HIV rapid test quality improvement trainers guide for further troubleshooting procedures in case of false or invalid test results.

Step 10: Record each quality control result in the 'Independent Quality Control Record Sheet' and complete all information as required. Maintain record of IQC testing for the screening test and confirmatory test on separate sheet. Also, indicate discordant or discrepant and invalid result in the sheet. Recording IQC test result in the spaces provided for it in the backs pages of HTS register. The record can be kept on separate file for IQC where HTS register cannot be used.

Sept 11: The facility manager must review and sign on a weekly basis the 'Independent Quality Control Record Sheet' to ensure IQC is performed as required and documented in full.

Step 12: If a test kit consistently gives false or invalid result, ALL KITS WITH THE SAME LOT NUMBER SHOULD BE PUT ASIDE AND NOT USED FOR FURTHER TESTING. The incident must be reported to the facility manager and district immediately including the name and lot number of the test kit and control samples. HIV testing should be continued with test kit with another lot number which is found to give correct result after IQC testing is conducted.

Note to reviewers:

- Note that this element is only applicable for facilities that are enrolled as pilot sites to monitor the quality of HIV rapid test kits . If the facility is not part of the pilot mark the element as not applicable.
- Check the records for IQC Control of the past 3 months. The facility is compliant if there is a weekly IQC Record Sheet for IQC testing that has been signed off by the facility manager for the past 3 months.

COMPONENT 4: HUMAN RESOURCES FOR HEALTH

15: Staff allocation and use

Commitment for Ideal Clinic elements 123 - 125

The facility has adequate number of staff in place with the correct skills mix for the services provided.

123	***Staffing needs have been determined in line with workload requirements***
124	***Staff appointed in line with the determined requirements***
125	***The facility has a dedicated manager***

Process

Step 1: Determine the staffing needs for the facility according to the package of service that is provided at the facility and the population served. This should be done in collaboration with the district office.

Step 2: The district office must sign off on the determined staffing needs and the approve the staff establishment for the facility.

Step 3: Should there be surplus staff in your facility, plan with district manager for redeployment.

Step 4: Should there be a need for additional staff, write a request to the district manager for the posts to be created, funded and filled.

Step 5: Participate in the recruitment and selection process as required.

Step 6: District manager to appoint a facility manager for facilities that have a headcount of more than 170 patients per day. In facilities that have a headcount of less than 170, a staff member must be dedicated as the facility manager. The suggested split between management and clinical functions should be 60% management and 40% clinical (rural) and 80% management and 20% clinical for facilities with a workload of more than 170 patients. Content of the job

description and performance agreement must be in line with the approximately 60/80 per cent management and 40/20 per cent clinical work principle.

Step 7: Use Annexure 89 to check whether the staff is appointed is inline with the determined needs (approved staff establishment).

Note to reviewers:

- Staffing needs must be reviewed at a minimum every five years, or earlier if the need arise.
- If the facility manager's post is vacant for less than three months and the facility has a formal letter from the sub-district/district that designate a staff member as the acting manager, the facility can score green.

Commitment for Ideal Clinic element 126

Staff members are aware of work allocations and perform as scheduled.

126 Work allocation schedule is signed by all staff members

Process

Step 1: Complete the work allocation schedule daily, weekly or monthly as appropriate for the facility. See Annexure 90.

Step 2: Each staff member must sign the schedule confirming that they are aware of their duty allocation.

Step 3: Place the schedule on the staff notice board for easy access to all staff members.

Commitment for Ideal Clinic element 127- 128

All staff understands the leave policy and a leave schedule have been developed to suit service needs. Every staff member has an individual staff file that contains up to date staff records.

127	***Leave policy is available***
128	***An annual leave schedule is available***

Process

Step 1: Obtain the public service leave policy from the district office.

Step 2: Share the contents of the public service leave policy with all staff members

- Explain the policy contents clearly to the staff so that they understand the leave process, emphasising the need for approval prior to going on leave, unless in an emergency situation.
- Staff to sign acknowledgment indicating that they are aware of the policy and its application. See Annexure 67.

Step 3: Draw up an annual leave schedule for all staff members taking into account the service needs of the facility. See Annexure 91.

Step 4: Print and place the annual leave schedule on staff notice board.

16: Professional Standards and Performance Management Development (PMDS)

Commitment for Ideal Clinic element 129

Staff is inducted to make them feel welcome, that they understand core information about their job and help them to settle into their new job and work environment.

129 Record of staff induction is available

Process

Step 1: Schedule induction training for all newly appointed staff. Staff should receive induction training within the first three months of being appointment.

Step 2: Training must cover at a minimum the following:

- Vision and mission of the district
- Batho Pele Principles
- Operational policies and procedures
- Health and Safety of patients and staff
- Quality improvement methodology
- Infection Prevention and Control
- Patient safety

Step 3: Keep attendance registers of the training conducted. See Annexure 12 as an example

Note to reviewers:

Obtain the list with the facility's staff establishment. Verify which staff members have been appointed in the past 12 months. Check on the training register whether these staff members have received induction training.

Commitment for Ideal Clinic element 130

Healthcare workers comply with legislation regarding registration with professional bodies

130 All healthcare workers have current registration with relevant professional bodies

Process

Step 1: On an annual basis that coincide with the relevant professional body's time frames for registration, request staff to provide a copy of their current registration with the relevant professional body.

Step 2: Obtain an updated list of appointed staff and tick off whether the staff member has submitted a copy of their registration.

Step 3: File the copies in a file that is clearly marked for this purpose.

Step 4: Use the list compiled in step 2 to verify, using Annexure 92, that all categories of healthcare workers have current registration with the relevant professional bodies.

Commitment for Ideal Clinic element 131

Entrench goal-oriented performance by staff members through appropriate performance agreements and reviews.

131 Performance Management guidelines are adhered to

Process

Step 1: Obtain the PMDS policy from the district.

Step 2: Explain the content of the PMDS policy clearly to all staff members.

Step 3: Ensure that each staff member has an approved and signed job description available.

Step 4: Use the prescribed PMDS templates to develop an individual Performance Management Agreement (PMA).

- ensure that the performance goals of the facility are reflected within the key result areas of individual staff members' PMAs
- PMA to be signed by the individual staff member and the facility manager after discussion and agreement
- submit signed original copies to district office by 15 April of the relevant financial year.

Step 5: Performance appraisal to be conducted six monthly using the PMDS evaluation templates. Evaluation templates available on the DPSA website. Note: Even if personnel records are kept at a central location, copies of staff PMAs and performance review documents must be available at the facility. Good practice prescribes that individual staff members and the facility manager refers to these documents regularly to track performance and staff development needs.

Step 6: Use Annexure 93 to verify that the guidelines for performance management has been adhered to.

Commitment for Ideal Clinic element 132 - 133

Create an environment that supports the professional development of staff to ensure the delivery of quality health services.

132	***Continued staff development needs are determined for the current financial year and submitted to the district manager***
133	***Training records reflect planned training is conducted as per the district training programme***

Process

Step 1: Develop a staff development and training plan based on the facility's service needs. This must be done in time to include training costs in the budget of the financial year.

Step 2: Submit to district manager by 15 April of the relevant financial year.

Step 3: Staff members should be released for the identified training taking into consideration the facility's staffing and service needs.

Step 4: Record all training in a register. See Annexure 12 as an example.

Commitment for ideal Clinic elements 134 - 135

Staff is disciplined and committed to providing quality health services.

134 The disciplinary procedure is available
135 The grievance procedure is available

Process

Step 1: Obtain the public service disciplinary and grievance procedures from the district office.

Step 2: Explain the contents of the disciplinary and the grievance procedures to all staff members.

Step 3: All staff must sign acknowledgement that they have been informed of both procedures and understand it. See Annexure 67.

Commitment for Ideal Clinic elements 136- 137

Staff work in a positive work environment.

136	***Staff satisfaction survey is conducted annually***
137	***The results of the staff satisfaction survey are used to improve the work environment***

Process

Step 1: In cooperation with the sub district/district human resource management unit, conduct the yearly staff satisfaction survey. As an example see Annexure 94.

Step 2: Sub district/district human resource unit must analyse the results and present to sub district/district Health Management Team (DHMT) with recommendations for improvement.

Step 3: Using recommendations from step 2, develop an action plan to address relevant weaknesses highlighted in the staff satisfaction survey report.

Step 4: Implement action plans in cooperation with sub-district/district.

Step 5: Staff satisfaction survey report and action plan must be available for inspection.

Commitment for Ideal Clinic elements 138 to 143

Occupational Health and Safety hazards are attended to.

138	***SOP for management of occupational health and safety incidents is available***
139	***Health and safety representative appointed (NA is staff establishment is less than 20 staff members)***
140	***Health and Safety committee appointed (NA if less than 2 safety reps)***
141	***Occupational Health and Safety incidents are managed and recorded in a register***
142	***Occupational health and safety risk assessment has been conducted in the past two years***
143	***Risk mitigation interventions are implemented for identified occupational health and safety risks***

Process

Step 1: Obtain the SOP for the management of occupational health and safety incidents from the district office. Verify that the content of the SOP is complete, use Annexure 95.

Step 2: Designate a health and safety representative if the staff establishment is more than 20. The designation must be done in writing and the period must be stipulated. For facilities that have less than 20 staff members, the manager of the facility must oversee matters relating to occupational health and safety.

Step 3: All health and safety representatives must receive appropriate training to ensure that the representatives can perform their duties effectively.

Step 3: Appoint a health and safety committee if the facility has more than two health and safety representatives.

Step 4: All occupational health and safety incidents must be reported by completing the WCL1 or WCL 2 forms for all staff that was involved in an occupational health and safety incident.

Step 5: Submit the forms to the sub-district/district office.

Step 6: Record all the occupational health and safety incidents in a register. The following information must be recorded in the register:

- summary of the incident
- summary of investigation conducted
- outcome of investigation
- recommendations
- date recommendation implemented

See Annexure 96 as an example of a register.

Step 7: Check the past six month's register to verify that the registers has been completed in full, see Annexure 97. The actions taken to manage the incident must be recorded in the register.

Step 8: Annually analyse the register to establish trends.

Step 9: Where trends have been identified, add activities to the quality improvement plan to prevent incidents from reoccurring.

Step 10: Risk assessment and management are planned and systematic processes to identify the hazards in the work environment which have the highest potential to cause harm with the aim of eliminating or mitigating hazards. Plan to arrange for an occupational health and safety risk assessment to be conducted by trained staff every two years (or more frequently if the need arise).

Step 11: Once the occupational health and safety risk assessment has been conducted, a report must be compiled which is to be signed off, dated and filed.

Step 12: There must be documented evidence of identified risks and the implementation of mitigating actions. The documented evidence could include reports, such as hazard identification and risk assessment reports, or minutes of meetings in which risk management is discussed, which must be signed and dated.

Note to reviewers:

An occupational health and safety incident is any injury that staff has sustained while being on duty. In cases where there is not clarity on whether the injury will qualify as an occupational health and safety incident, the incident must still be reported. The determining body will evaluate the case and make a finding.

COMPONENT 5: SUPPORT SERVICES

17. Finance and supply chain management

Commitment for Ideal Clinic element 144

Ensure the availability of key resources at all times through the application of good financial management

144 Facility has a dedicated budget

Process

Step 1: Sub district/district finance manager to set up the facility as a cost centre.

Step 2: Ensure that facility managers are part of the discussion at sub district/district level that will result in the facility's budget allocation.

Step 3: Allocate financial resources in line with the facility needs.

Step 4: Develop control measures for rational budget utilisation and expenditure.

Step 5: Using the monthly expenditure report as received from sub-district/district, compare the report to the monthly commitment register you have in your records for the relevant month. See Annexure 98.

Step 6: Participate in the quarterly sub-district/district expenditure review meetings.

Step 7: Query any differences/discrepancies in expenditure balances with the sub-district/district and make relevant submission for correction of the discrepancies. After the corrections have been authorised, reallocate the funds according to budget pressures.

Commitment for Ideal Clinic elements 145

Ensure adequate replenishment of supplies through a supply chain management system. Suppliers will be monitored through Service Level Agreements (SLAs) to ensure compliance.

145 Facility has a standard operating procedure for obtaining general supplies

Process

Step 1: Ensure that the facility has a standard operating procedure for procuring general supplies.

Step 2: Set a minimum and maximum value for each item procured based on the facility's use.

Formula to calculate minimum and maximum levels

Formula Min level = Lead Time (time it takes from the moment the item is ordered until it is received and ready to be used) + Safety Stock (amount of stock to hold because of something that could occur to delay the lead time)

If the process is working smoothly, you will receive the item you ordered right as you get into the safety stock.

Formula Max level = Min + (Min/2)

Example:

Min = 30 days lead time + 15 days of safety stock = 45 days

Max = 45 + (45/2) = 67.5 round up to 68 days

The only other number that is needed is the quantity of the item that is used per day. This is used to translate the number of days to a quantity of the item.

For example, 50 surgical gloves are used daily

Min stock level = 45 days x 50 gloves = 2 250 gloves

Max stock level = 68 days x 50 gloves = 3 400 gloves

* the formulas can be adjusted to suite the circumstances in the facility to ensure that stock do not run out.

Step 3: Replenish item once the minimum level of an item has been reached.

Step 4: Obtain a copy of the relevant item contracts and use the terms and conditions of the contract to ensure acceptable turn-around times and to apply penalties where necessary.

Step 5: Keep all source documents safely.

18: Hygiene and cleanliness

Commitment for Ideal Clinic elements 146- 151

The entire facility is clean at all times.

146	***All cleaners have been trained on cleaning procedures***
147	***Cleaning schedules are available for all areas in the facility***
148	***Cleaning is carried out in accordance with the schedule***
149	***Disinfectant, cleaning materials and equipment are available***
150	***All work completed is signed off by cleaners and verified by manager or delegated staff member***
151	***All service areas are clean***

Process

Step 1: Ensure that cleaners have been appropriately trained and are fully aware of their duties.

- if the clinic has contract cleaners, meet with the contractor and ensure that the cleaners in your facility have been trained and have a clear understanding of their duties.

Step 2: Identify, schedule and record additional training needs of cleaners.

Step 3: Maintain records of training of each cleaner. See Annexure 12 as an example

Step 4: Compile daily, weekly and monthly cleaning schedules for all areas in the facility. File in the designated file for cleanliness. See Annexure 69 as an example.

Step 5: Obtain the National Ideal Clinic Health Commodities Specification Catalogue that contains specifications for cleaning equipment from www.health.gov.za. Verify that the facility has the prescribed list of non-negotiable disinfectant, cleaning materials and equipment and ensure that facility has disinfectant, cleaning materials and equipment (Annexure 99) at all times.

Step 6: Obtain material safety data sheets for all cleaning material used in the facility from the sub-district/district office. The material safety data sheets must comply with the Hazardous Chemical Substances Regulations, 1995, see Annexure 100.

Step 7: Ensure that cleaning is in line with expected standards and that cleaners take responsibility for their allocated areas through appropriate supervision and sign-off on check lists for toilets. The manager or the professional health care staff member delegated by the manager to supervise the cleanliness of areas must also sign the checklist daily and indicate on the checklist whether he/she is satisfied with the cleanliness of the areas. The checklist must be filed in the cleanliness file and should be used to guide performance evaluation of cleaners. See Annexure 70 as an example.

Step 8: Use Annexure 101 to verify that cleaners have signed of the work in all areas

Step 9: Conduct daily inspections of the service areas of the facility using the Cleaning Inspection Checklist. See Annexure 102. If any areas are not clean, discuss with the relevant cleaner and get them to clean again. Instruct cleaners to inform the facility manager immediately of any repairs required.

Step 10: To check whether the cleaning is carried out in accordance with the schedule (element 148), check whether the cleaning checklist is aligned with the cleaning schedule (times and tasks on the schedule) and the work were signed of.

Step 11: Instruct cleaners to close taps properly and switch off unnecessarily lights.

Commitment for Ideal Clinic element 152

Staff and patients will be protected from communicable diseases through good hygiene practices.

152 Hand hygiene facilities are available

Process

Step 1: District management to ensure that all clinics have running water

- if there is a break in the normal supply of clean running water, request repairs using the local prescribed process.

Step 2: Conduct a weekly inspection of all consumables to ensure the correct quantity is available. See Annexure 103.

Step 3: Ensure the availability of toilet paper, liquid hand wash soap and disposable hand paper towels in the appropriate areas

Commitment for Ideal Clinic elements 153 - 155

Staff and patients will be protected from communicable diseases through good practice disposal of general and health care risk waste.

153 SOP for managing general and health care waste is available

154 Health care waste is managed appropriately

155 Central storage are for health care waste is appropriate

Process

Step 1: Ensure that the facility has a SOP for managing general and health care risk waste. Verify that the content of the SOP contains the minimum requirement. See Annexure 104.

Step 2: Check that health care waste is managed appropriately. See Annexure 105.

Step 3: Display on notice board in dirty utility room the instructions for the correct use of coloured bin liners to be used for sanitary disposal and general waste management.

- medical waste disposal bins//boxes must be lined with red plastic
- general bins and sanitary disposal bins/boxes must be lined with the appropriate coloured bin liners
- all disposal bins/boxes must be clean and intact
- broken disposal bins/boxes must be replaced with new ones

Step 4: Place the sanitary, health care risk waste and general disposal bins in the appropriate areas.

- disposal bins/boxed must never be more than three quarters full
- disposal bins/boxes must be emptied as needed.

Step 5: Conduct spot checks on the status of the sanitary and general disposal bins/boxes to ensure compliance to the infection control measures. Non-functional sanitary disposal bins and general waste bins (broken and/or damaged) must be replaced by ordering new ones.

Step 6: Instruct the cleaners to inform the facility manager immediately if the bin liners is getting close to the minimum level.

Step 7: Ensure that health care waste is stored in an appropriate central storage area. See Annexure 106.

Commitment for Ideal Clinic element 156

Toilets are available and functional at all times to ensure staff and patient safety

156 All toilets are clean, intact and functional

Process

Step 1: Obtain checklist for functional toilet status.

Step 2: Conduct a spot check of the toilets in your facility to see that they are intact and functional. See Annexure 107.

Step 3: If the toilets are not functional, put up a sign on the toilet door stating “Not Working - Do Not Use”

Step 4: Ensure prompt repairs of broken toilets.

Commitment for Ideal Clinic elements 157

The facility environment must be aesthetically pleasing to contribute positively to the mental health of patients and staff

157 Exterior of the facility and grounds are clean and well maintained

Process

Step 1: Appoint the required number of groundsmen as per the approved organogram. At facilities where groundsmen are shared with other facilities, ensure that a schedule is drawn up that indicates the schedule of the groundsmen at the different facilities.

Step 2: Ensure that groundsmen have been appropriately trained and are fully aware of their duties. This includes orientation of new groundsmen.

- if you have contract groundsmen, meet with the contractor and ensure that the groundsmen in your facility have been trained and have a clear understanding of their duties.

Step 3: Maintain records of training of each groundsman. Annexure 12 as an example.

Step 4: Do spot checks of the exterior to check whether the facility is neat and clean. See Annexure 108.

Step 5: Instruct groundsman to clean areas where weaknesses are identified.

Commitment for Ideal Clinic elements 158- 161

Waste is stored and removed from the facility in line with acceptable standards to ensure patient and staff safety

158	***A signed waste removal service level agreement between the health department and the service provider is available***
159	***Health care risk waste is removed in line with the contract***
160	***The service level agreement for waste removal and disposal of waste is monitored***
161	***Breaches in waste removal contract are escalated to the relevant authority***

Process

Step 1: Develop/obtain the SOP for waste management. Refer to section on waste management in the Practical Manual for implementation of the National IPC strategic framework for guidance. Available from www.health.gov.za.

Step 2: Train all staff on the importance of waste handling, segregation and the purpose of the colour categorisation.

Step 3: Maintain records of training of all staff. See Annexure 12 as an example.

Step 4: Place a poster for waste segregation (Annexure 53) in the dirty utility room.

Step 5: Conduct spot checks at the facility waste generation points to determine that correct waste handling and segregation is taking place.

Step 6: If the correct procedures for waste management are not adhered to, correct weaknesses through instructions to relevant staff.

Step 7: Ensure that all waste is stored in an access controlled general and health care risk waste storage areas

- if designated area is not available or conforming to required standard (refer to checklist of element 160), place a works order.

Step 8: Obtain and keep a copy of the signed waste removal SLA from the sub-district/district

Step 9: Read and understand the SLA so you are aware of the service delivery requirements that the waste removal service provider must comply with.

Step 10: Monitor waste removal to ensure that the service provider complies with the requirements of the SLA.

Step 11: Record each incident of non-compliance and escalate to the sub-district/district office.

Note to reviewers:

- Element 159: Removal of waste must be documented/recorded for example in a register. Assess records from the last three months to see if waste is collected as indicated in the service level agreement.
- Element 160: Monitoring compliance with the service level agreement will ensure that breaches in service delivery are identified. This could include a monitoring checklist, minutes of meetings, reports, receipts and disposal certificates
- Element 161: Evidence reflecting escalation of the breaches to the relevant authority must be available. This must be recorded in a document (evidence of submission to relevant authority must be available) or sent electronically via email.

Commitment for Ideal Clinic elements 162

The facility is pests free to ensure that the environment is clean

162 Records show that pest control is done according to schedule

Process

Step 1: Compile a pest control schedule for the facility. The frequency will depend on the current situation of the facility. If the facility is invested with pests, more frequent pest control will be needed. The schedule can be changed from time to time as the situation change in the facility. See Annexure 109 as an example.

Step 2: Monitor that pest control is conducted according to the set schedule. The manager must sign the schedule once the pest control has been conducted.

Note to reviewers:

Pest control should be conducted by the district office or through an appointed company. In rural areas and facilities where pests are not a big problem spraying with a high-performance residual insecticide spray is acceptable (example Fendona).

19: Security

Commitment for Ideal Clinic elements 163 - 167

Patient and staff safety is assured at all time.

163	***Safety and security SOP is available***
164	***Perimeter fencing is intact***
165	***Parking for staff on the facility premises***
166	***There is a standard security guard room OR the facility has an alarm system linked to armed response***
167	***There is a security guard on duty OR the facility has an alarm system linked to armed response***

Process

Step 1: Ensure that the facility has a safety and security SOP. The SOP must cover at a minimum the following:

- High risk areas and the specific security needs for these areas
- Access control within the facility
- Reporting of security incidents (see register for security breaches)
- Training of personnel on the management of alarms (where applicable), provision of guarding services and patrolling
- Provision of guarding services
- Patrolling of the health facility
- Equipment for security personnel. See Annexure 110.

Step 2: Conduct a monthly walk about to ensure that perimeter fencing is intact, gates are functioning, and the guard room is neat and tidy.

Step 3: If the clinic does not have parking for staff this must be requisitioned through the district/provincial infrastructure unit.

Step 4: The guard room must conform to the standards (see Annexure 111) or have an alarm system that is linked to armed response. Facilities that have an alarm system that is linked to armed response must ensure that the alarm is serviced as prescribed by the company that has installed the alarm.

Step 5: Inform the district/provincial infrastructure unit in writing of identified weaknesses in regard to fencing, parking and guard room.

Step 6: Keep a copy of correspondence with district infrastructure in this regard.

Step 7: Ensure that there is a duty roster for security officers where there is not an alarm system that is linked to armed response.

Note to reviewers:

- Facilities with the structural make-up that render perimeter fencing and separate guard house impossible/unnecessary e.g. in a multi story building in a city must score not applicable at element 164 and the section for the security guard room on element 166.
- The parking area for staff can be outside the perimeter of the facility (example in a building, area next to the facility). This parking area must however be within 500m walking distance and the parking area must have specific allocated space for staff working at the facility. Parking in the street is not acceptable as it is not allocated to staff.

Commitment for Ideal Clinic element 168 -169

Optimal security services are delivered at the facility to ensure safety and security of patients and staff.

168	***Security services rendered in according to contract OR provincial security policy/facility SOP***
169	***A signed copy of the service level agreement between the security company and the provincial department of health is available***

Process

Step 1: Obtain and keep a copy of the signed security SLA from the sub-district/district

Step 2: Read and understand the SLA so that you are aware of the service delivery requirements that the security service provider must comply with. Ensure that these services include the control of prohibited items.

Step 3: Orientate your staff on the terms of the SLA.

Step 4: Monitor if security services complies with the requirements of the SLA OR standard operating procedure. See Annexure 112.

Step 5: If weaknesses are identified discuss with the security officers working at your facility to take corrective action.

Step 6: If weaknesses persist call a meeting with the management of the security service provider. Keep records of these meetings.

Step 7: Escalate repeated incidents of non-compliance to the district office.

Note to reviewers:

For element 169: In facilities where provincial/district/in house staff performs the security duties, the content of the job description of the appointed staff must be reviewed. Check whether the job description addresses the facility's need in regard to security issues. Job descriptions for security staff must be signed.

Commitment for Ideal Clinic element 170

The safety of staff and patients are protected by managing security breaches appropriately.

170 Security breaches are managed and recorded in a register

Process

Step 1: Record all security breaches in a register or the security incident book. See Annexure 113 as an example of a register.

Step 2: Record how the breach was managed and what measures were taken to prevent the reoccurrence of the breach.

Step 3: Verify that the register has been completed in full and that all breaches were managed, use Annexure 114.

Step 4: Once the investigation of the breach has been finalised the security staff must sign off in the register.

Note to reviewers:

Where no security breaches occurred in a month, a “Null” record must be entered in the register and the register for that month must also be signed off.

20: Outbreak and Disaster preparedness

Commitment for Ideal Clinic element 171

Patients and staff are protected against the risk of injury due to fire.

171 Functional firefighting equipment is available

Process

Step 1: Ensure that functional firefighting equipment (Annexure 115) is available in the facility.

Step 2: The district manager must ensure that there is a service level agreement with a competent service provider for servicing the facility's firefighting equipment.

Step 3: Conduct monthly inspections to ensure that equipment is present and intact.

Step 4: The service provider must service firefighting equipment at least yearly.

Step 5: A record must be kept of the services conducted. See Annexure 116 as an example. The facility manager must remind the service provider in good time of the next scheduled service date.

Step 6: If an item(s) of firefighting equipment has been used, immediately contact the service provider to restore functionality for future use.

Step 7: Escalate to sub-district/district manager in writing if corrective action is not timeously taken.

Commitment for Ideal Clinic element 172 -175

The clinic is at ready for emergency evacuation all times.

172	***Evacuation plan is displayed in the manager's office and the main entrance***
173	***Contact numbers of healthcare personnel required in emergencies are available in the management offices and at reception***
174	***Emergency evacuation procedure is practiced annually***
175	***Deficiencies identified during the practice of the emergency evacuation drill are addressed***

Process

Step 1: Obtain a floor plan of the facility from the district office. Where there is no floor plan available from the district office, draw a floor plan. Excel can be used or neatly hand draw the floor plan.

Step 2: Use the floor plan to develop an emergency evacuation plan that visually displays the evacuation paths.

Step 3: Indicate all emergency exists, assembly points, main electrical power switch, main water shut off valve and firefighting equipment on the floor plan.

Step 4: Add in directional arrows to show the way to the various emergency exit points as well as the emergency assembly point. See Annexure 117 for an example of an evacuation plan.

Step 5: Visibly display the evacuation plan in the manager's office and the reception area.

Step 6: Ensure that the contact numbers of healthcare personnel that will be required in emergencies is in the file for contact details in the manager's office and reception. Where there is no manager's office in the facility the contact numbers must be available in the most accessible office in the facility.
Contact details of the following healthcare personnel must be included:

- District outbreak team,

- District Specialist Team OR General Medical Practitioner allocated to the facility,
- Local area manager,
- Referring district hospital (casualty section),
- District manager,
- Facility manager,
- Facility professional staff

Step 7: Conduct annually an evacuation drill. **Note: No critical patient must be left unattended during the evacuation practice.** Allocate a trained staff member to attend to them

- assign/designate roles to staff
- choose a date and time to practice evacuations that is not made known to staff
- set the scene and commence the evacuation drill in line with the plan.

Step 8: Debrief and give feedback to staff.

Step 9: Draw up an emergency evacuation drill practice report (see Annexure 118 as an example) and file. This report must include recommendations for improvement if applicable.

Step 10: Plan and implement remedial action within two weeks.

Step 11: Rerun the evacuation practice if necessary.

Commitment for Ideal Clinic element 176

The facility staff is prepared to manage outbreaks effectively

176	***Standard Operating Procedure for outbreak notification and response are available***

Process

Step 1: Obtain the National Guidelines on Epidemic Preparedness and Response from www.health.gov.za.

Step 2: Use the Guideline to develop a SOP for outbreak notification and response for the facility. District offices should be guiding this process.

Step 3: All staff members to sign the acknowledgement form that they are aware of the content of the SOP. Attach this to the back of the SOP and file the document. See Annexure 67 as an example.

21: Transport

Commitment for Ideal Clinic element 177 to 180

Patients and staff are transported safely.

177	***All official vehicles used to render services or transport patients are licensed annually***
178	***All official vehicles used to render services or transport patients are serviced according to manufacturer's schedule***
179	***All staff driving official vehicles to render services or transport patients have a valid driver's license***
180	***All staff driving official vehicles to render services or transport patients have a valid professional driving permits where applicable***

Process

Step 1: If the facility uses official vehicles, draw up a schedule indicating when each vehicle is due for license renewal. Check schedule monthly which vehicles are due for license renewal and renew the license where indicated.

Step 2: If the facility uses official vehicles, draw up a schedule indicating when each vehicle is due for service. Check monthly which vehicles are due for a service and schedule the service accordingly.

Step 3: Draw up a schedule for staff that render transport services to indicate when their licenses/permits will expire. Check monthly:

- Which staff member's licenses will expire within the next three months. Remind those staff members to renew their licenses/permits.
- That the staff members whose licenses has expired in the specific month has renewed their licenses/permits.

Note to reviewers:

Facilities that do not make use of official vehicles mark not applicable for element 177 to 180.

COMPONENT 6: INFRASTRUCTURE AND SUPPORT SERVICES

22. Physical space and routine maintenance

Commitment for Ideal Clinic element 181

The physical space and environment is conducive to rendering quality health services.

181 Clinic space accommodates all services and staff

Process

Step 1: Determine if the size of the facility is sufficient to provide services based on the population to be served and PHC package of services provided. Refer to the size classification and facility reorganization sections in the ICSM manual to determine the required number of rooms/areas etc.

Step 2: Once the approximate classification has been calculated according to the process as set out in the ICSM manual, use Annexure 119 to determine whether the size and configuration of the facility is sufficient.

Step 3: Prepare and submit a motivation to the district office for additions/renovations if needed.

Step 4: Make regular follow up with the district manager for feedback on this matter.

Commitment for Ideal Clinic element 182

The facility has adequate natural ventilation or functional mechanical ventilation.

182	***Clinical service areas have natural ventilation or functional mechanical ventilation***

Process

Step 1: Ensure that the facility has natural ventilation (windows and doors that can be opened, cross ventilation between doors and windows) or functional mechanical ventilation (i.e. ceiling fans or air conditioners) in service areas.

Step 2: Use Annexure 120 to assess whether the facility has adequate ventilation in service areas.

Commitment for Ideal Clinic element 183

The facility is accessible for people in wheelchairs.

183 There is access for people in wheelchairs

Process

Step 1: Using the wheelchair access requirement checklist to check whether the facility complies with the criteria. See Annexure 121.

Step 2: Should the facility not comply, apply for the relevant alterations through the sub-district/district manager by following the relevant provincial protocol.

Commitment for Ideal Clinic elements 184 - 186

The facility infrastructure must be maintained to provide an environment conducive for health service delivery.

184	***Maintenance schedule for building(s) and grounds are available***
185	***Building(s) is maintained according to schedule***
186	***Building(s) complies with safety regulations***

Process

Step 1: Using Annexure 122, compile a checklist of major infrastructure repairs and maintenance work required.

Step 2: Log a request to have major repairs onto the district's annual major maintenance plan.

Step 3: Obtain the maintenance schedule for the current financial year for the facility from the sub-district/district.

Step 4: Do regular follow-up to ensure that the maintenance is conducted according to the schedule.

Step 5: Follow-up with the sub-district/district if maintenance is not done according to schedule. Document all follow-ups. See Annexure 123.

Step 6: As soon as items for minor repair are identified, complete and submit a works order. Keep record of orders submitted and track progress. See Annexure 123 as an example.

Step 7: If no action has been taken within one week, escalate to sub-district/district.

Step 8: Obtain the certificates from the sub-district/district that is required to ensure that the facility is compliant with all safety regulations. File in the building maintenance file. See Annexure 124.

23. Essential equipment and furniture

Commitment to Ideal Clinic elements 187 - 191

Appropriate furniture and essential equipment is available in every consulting room.

187	***Furniture is available and intact in service areas***
188	***Essential equipment is available and functional in every consulting areas***
189	***Staff are trained on the use of essential equipment***
190	***Standard Operating Procedure for reactive maintenance of medical equipment is available***
191	***Maintenance plan for essential equipment is adhered to***

Process

Step 1: Obtain the National Ideal Clinic Health Commodities Specification Catalogue that contains a standardised list with specifications for furniture from www.health.gov.za

Step 2: Obtain the list for the furniture and essential equipment required in the consulting rooms

- consulting room furniture Annexure 125
- essential equipment Annexure 126

Step 3: Using the lists for furniture and essential equipment required in the consulting room, conduct a quarterly stock taking and ensure that all the items are available

Step 4: Ensure that missing items are budgeted for.

Step 5: Order missing items using the standard procurement procedure.

Step 6: Immediately follow up if items were not received on the indicated date.

Step 7: Schedule in-service training for all healthcare personnel on the equipment that is used in the facility. If there is equipment that staff is not familiar with, arrange through the sub district/district office that the supplier of the equipment conducts training for the healthcare personnel. Keep a register of all training conducted; see Annexure 12 as an example.

Step 8: Ensure that the reactive SOP for the maintenance of all medical equipment is available.

Step 9: Compile a maintenance schedule for the following equipment (see Annexure 127 as an example):

- Automatic External Defibrillator (AED) OR ECG monitor and defibrillator
- Pulse oximeter with adult & paediatric probes (recalibrated)
- Non invasive electronic blood pressure monitoring device including paediatric, adult & large adult cuff sizes (recalibration) (cuff bladders, valves and tubing replaced)
- Scales (recalibration),
- Hemoglobin meter (recalibration)

Step 10: Sign off on the maintenance schedule when the maintenance for specific equipment has been performed.

Step 11: Follow-up with the sub-district/district office if maintenance is not done according to schedule.

Commitment to Ideal Clinic elements 192 - 195

Facilities must be able to successfully resuscitate patients as the need arise.

192	***Resuscitation room is equipped with functional basic resuscitation equipment***
193	***Emergency trolley is restored daily or after each use***
194	***There is an emergency sterile obstetric delivery pack***
195	***There is a sterile pack for minor surgery***

Process

Step 1: Obtain the National Ideal Clinic Health Commodities Specification Catalogue that contains a standardised list with specifications for equipment and supplies needed for the resuscitation room, emergency trolley, emergency sterile obstetric delivery pack and sterile pack for minor surgery from www.health.gov.za.

Step 2: Conduct regular audits on emergency equipment using the following schedule:

- resuscitation room: Annexure 128
- emergency trolley: Annexure 129
- emergency sterile obstetric delivery pack: Annexure 130
- sterile pack for minor surgery: Annexure 131

Step 3: Keep record of the completed audit lists for future reference.

Step 4: Designate a professional nurse to ensure on a daily basis that the emergency equipment as stipulated in Step 2 are available, clean and functional.

Note to reviewer:

Emergency sterile obstetric delivery pack and sterile pack for minor surgery not to be opened during assessment, check only expiry dates and the contents list outside the pack.

Commitment for Ideal Clinic element 196 to 197

Oxygen must be consistently available to patients when needed.

196	***Oxygen cylinder with pressure gauge is available in resuscitation/ emergency room***
197	***Oxygen available in the cylinder is above the minimum level***

Process

Step 1: The facility's mobile oxygen cylinder in the resuscitation/emergency room must be fitted with a functional gauge at all times.

Step 2: The emergency oxygen cylinder has sufficient volume and pressure at all times. Designate a staff member to check this on a daily basis.

Step 3: The designated staff member must complete the check sheet (See Annexure 132 as an example) on a daily basis to ensure that the oxygen level is as prescribed (above the minimum level).

Step 4: Should the oxygen in the cylinder be below the prescribed level contact the service provider to have the cylinder refilled or exchanged with a full one.

Commitment for Ideal Clinic element 198

Imaging services is safe to use.

198 Imaging service unit is accredited

Process

Step 1: Ensure that the imaging services (can include radiography and ultrasound) must have a valid accreditation certificate. Obtain this certificate from the Provincial authority.

Note to reviewers:

If the facility do not provide imaging services, mark not applicable.

Commitment for Ideal Clinic element 199

Assets in the facility are controlled.

199 An up-to-date asset register is available

Process

Step 1: Obtain an updated asset register from the sub-district/district office.

Step 2: Do regular spot check to check whether the assets in the facility correspond with the asset register of the sub-district/district office. See Annexure 133.

Step 3: Report any discrepancies to the sub-district/district office; keep record of the communication done.

Step 4: Report any stock that is lost due to theft immediately to the sub-district/district office to ensure that the asset register is kept up to date. Keep record of reports sent.

Commitment to Ideal Clinic element 200

The facility uses space optimally.

200 Redundant and non-functional equipment is removed from the facility

Process

Step 1: If there are any items of equipment found to be redundant, inform the sub district/district to reallocate this to another facility.

Step 2: If there are any items of equipment found to be beyond repair, have this condemned and disposed of. Complete an asset disposal form for the equipment. See Annexure 134 as an example.

Step 3: Update asset register accordingly.

Note to reviewers:

Check whether there is any redundant equipment or non-functional equipment in the facility.

24. Bulk supplies

Commitment for Ideal Clinic elements 201 - 202

Facilities must have clean, fresh running water and backup supply available at all times.

201	***Facility has a functional piped water supply***
202	***Facility has emergency water supply***

Process

Step 1: In cooperation with the local municipality ensure that there is clean piped water to the facility.

Step 2: Where there is no piped water ensure that the sub-district/district has planned for the installation of piped water.

Step 3: The 24-hour contact number of the local municipality's water supply department must be prominently displayed on the facility's notice board together with other emergency numbers of essential services.

Step 4: Ensure that the facility has access to emergency water supply in the form of:

- water tanks that are regularly filled by the local municipality. The water level of the tank should be checked at least every fortnight.
- tanks on trailers that are brought to the facility when there is a break in piped water supply. A short SOP describing the process to follow to arrange for the backup water supply must be available.

Note to reviewers:

Element 202: Emergency water supply must be available. Water can be made available through amongst other containers with lids or water tanks (Jojos) or access to water trucks (this can be documented evidence). Documented evidence should be in the format of a (signed and dated) that outlines the process to follow for tanks on trailers to be brought to the facility.

Commitment for Ideal Clinic elements 203

Facilities must have uninterrupted electricity supply.

203 Facility has access to a functional back-up electrical supply

Process

Step 1: In cooperation with the district infrastructure unit ensure that functional back-up electricity is available at the facility.

Step 2: Back-up electrical supply must be available in the form of:

- a generator permanently stationed at the facility OR
- Uninterrupted Power Supply (UPS) OR
- Solar power

Step 3: If back-up electricity to the facility is in the form of a generator, assign a staff member to check the fuel levels on a monthly basis and after every use.

- report and correct any defects
- make sure that the emergency contact number for the generator maintenance is prominently displayed on the facility notice board.

Step 4: Verify that the back-up electricity supply is functional and connected to essential equipment. See Annexure 203.

Commitment for Ideal Clinic element 204

Removal of sewerage must be properly managed to ensure a safe and hygienic facility.

204 Sewerage system is functional

Process

Step 1: In cooperation with the local municipality, ensure that the facility is serviced by a piped sewerage removal system or a septic tank system.

Step 2: Should the facility experience problems with the sewerage system log a call for repairs with the district maintenance services.

Step 3: Make sure that the emergency contact number for the district maintenance services and the local municipality is prominently displayed on the facility notice board.

Note to reviewers:

When conducting a status determination observe that the sewerage system is functional, drains must not be blocked, both inside as well as outside the facility. There must also be no leaking drain pipes outside the building. Where the sewerage system is not functional, check that works orders has been completed to report it and follow-ups have been done where needed.

25. ICT infrastructure and hardware

Commitment for Ideal Clinic element 205

A functional telephone system must always be available in the facility to allow proper communication.

205 There is a functional telephone in the facility

Process

Step 1: Should the landline not be functional, contact the relevant service provider.

Step 2: If the fault persists for more than three days escalate it to the district.

Step 3: Keep record of all maintenance and repairs of telephone lines.

Commitment for Ideal Clinic elements 206 - 208

Functional Information Communication Technology (ICT) equipment (computer, printer and e-mail) must be available.

206	***There is a functional computer***
207	***There is functional printer connected to the computer***
208	***There is internet access***

Process

Step 1: If there is no computer with printer and e-mail in the facility, order the ICT equipment using the ICT procurement order form. The ICT equipment purchase agreement must include maintenance.

Step 2: Update the asset register accordingly

Step 3: In the event that the ICT equipment is not functional, order the repair by logging a call with district ICT support.

Step 4: Using the district training plan, request training for relevant facility staff in correct use of the ICT equipment.

Step 5: Ensure that the facility has internet/intranet (that allows access to all required applications) access.

COMPONENT 7: HEALTH INFORMATION MANAGEMENT

26. District Health Information System (DHIS)

Commitment for Ideal Clinic elements 209 - 214

Facilities generate and record accurate information for their own use and submission to district, provincial and national levels.

209	***Facility performance in response to burden of disease of the catchment population is displayed and is known to all clinical staff members***
210	***National District Health Information Management System policy OR Provincial SOP aligned with National Policy is available***
211	***Clinical personnel and data capturer trained on the facility level Standard Operating Guidelines for data management***
212	***Relevant DHIS registers are available and are kept up to date***
213	***Facility submits all monthly data on time to the next level***
214	***There is a functional computerised patient information system***

Process

Step 1: All clinical staff must be conversant with the burden of disease in their catchment population.

Step 2: The PHC package of services provided at the facility must be based on the burden of disease for the catchment area.

Step 3: Ensure that professional nurses and data capturers have been trained on the District Health Management Information System Policy

Step 4: Ensure that professional nurses and data capturers have been trained on the Facility Level Standard Operating Guidelines for Data Management

Step 5: Maintain records of training. See Annexure 12 as an example

Step 6: Data generated by the facility must be recorded in the approved PHC registers and kept up to date.

Step 7: Verify that monthly data that was captured are correct.

Step 8: Ensure that graphs are updated to the last quarter's data.

Step 9: Sign off data report.

Step 10: Submit all monthly data on time to the next level.

Step 11: Discuss facility performance using data/information in facility's monthly meetings.

Step 12: Correct data based on the sub-district/district's feedback where relevant. Document all evidence of monthly data feedback received from sub-district/district.

Step 13: In cooperation with national, provincial and districts offices, install and train staff on the electronic Health Patient Registration Information System/Primary Healthcare Information system

Step 14: Monitor that every patient is registered on the Health Patient Registration Information System.

COMPONENT 8: COMMUNICATION

27. Internal communication

Commitment for Ideal Clinic element 215

Recommendations from the district quarterly performance review meetings are used to discuss the performance of the facility and plan corrective actions to improve facility performance.

215 There are sub-district/district quarterly facility performance review meetings

Process

Step 1: In cooperation with the district manager and area managers set dates for the quarterly performance review meetings as part of the sub-district/district annual calendar.

Step 2: Review each programme's performance against predetermined targets and explain reasons for variations.

Step 3: The facility manager must schedule a meeting with the facility staff one week before the quarterly performance review meetings to prepare the facility's presentation using the relevant provincial template.

Step 4: Deliver the facility's presentation and answer all questions at the quarterly performance review meetings.

- discuss what actions will be taken to achieve set targets and what changes need to be made within the facility. Make notes during the discussion.
- record activities, challenges and any good practices that you could replicate in your own facility from other facilities presentations

Step 5: File a copy of the presentation electronically and make sure that computer content is backed up appropriately.

Commitment for Ideal Clinic element 216

Staff in the facility is well informed about the facility's current performance and future plans.

216 A staff meeting is held at least quarterly within the facility

Process

Step 1: Draw up a quarterly meeting schedule in consultation with all staff members. Facilities are free to have more frequent meeting on an ad hoc basis.

Step 2: Include quarterly meeting dates on the Annual Facility Calendar. See Annexure 136 as an example.

Step 3: Display quarterly meeting schedule for the year on the staff notice board. Attendance of all staff is compulsory except those who are on leave.

Step 4: Develop an agenda for the meeting. See Annexure 137 as an example.

Step 5: All staff who attended the meeting must sign the attendance register. See Annexure 138 as an example.

Step 6: Designate a staff member to take minutes.

Step 7: Minutes of the meeting will be available within three working days after the meeting and will be filed electronically in date order. Minutes are available for all staff to read.

Step 8: Review the action points after the meeting and ensure that all activities that were agreed upon at the meeting, are executed.

Commitment for Ideal Clinic element 217

Staff is knowledgeable about all relevant policies and notifications. This knowledge is used to improve the facility's functioning and services to the patients.

217 Staff members demonstrate that incoming policies and notices have been read and are understood by appending their signatures on such policies and notifications

Process

Step 1: When new policies and notifications are received, check if they replace existing policies and notices.

Step 2: Discuss the new policies and notices with staff immediately.

Step 3: Check to see that the relevant staff members understand the changes and determine if further training may be required. If training is required, request this using the district training protocol.

Step 4: Staff members that must implement and/or have knowledge of the policies/guidelines and notices must sign the acknowledgement form for the specific policies/guidelines and notices. Attach this to the back of the new policy/guidelines or notice and file the document. See Annexure 67 as an example.

Step 6: Verify that all staff has signed the acknowledgement form for the National guidelines for priority health conditions. See Annexure 139.

Step 5: If there are further questions regarding the policies and notices seek relevant answers from the relevant source or your local area manager.

28. Community engagement

Commitment for Ideal Clinic elements 218 - 219

The community being served by the facility supports the facility management and staff by being involved in service planning and taking ownership and pride of their facility and its functioning.

218	*There is a functional clinic committee*
219	*Contact details of clinic committee members are visibly displayed*

Process

Step 1: Using the District Governance Structures Policy (www.health.gov.za) understand the roles, responsibilities and activities of the clinic committee as well as how to get a functional clinic committee established.

Step 2: Determine whether there is a clinic committee in place. If so, ascertain whether it is functional. See Annexure 140.

Step 3: If clinic committee is not in place or not functional obtain guidance through the district manager from the office of the MEC for Health.

Step 4: In cooperation with the office of the MEC obtain nominations of clinic committee members and ensure that the appointment process is taken to completion.

Step 5: Develop a clear and legible list of the names of clinic committee members and all their contact details

- place this list on patient notice board in the waiting area
- update this list when there are changes to clinic committee members.

Step 6: In cooperation with the chairperson of the clinic committee:

- develop a schedule of monthly meetings
- request training for clinic committee members from the district

- attend clinic committee meetings, ensure that agenda is developed, register is kept, and minutes are taken. See Annexure 137 / Annexure 138 as an example
- follow up actions arising out of clinic committee meetings.

Commitment for Ideal Clinic element 220

Promote community ownership of the facility and its functions while strengthening health promotion and disease prevention in the community.

220 Facility has an annual open day

Process

Step 1: In consultation with facility staff and community leaders plan for open days. See an example of suggested services and activities for an open day. See Annexure 141 as an example.

Step 2: Log dates of the open day in the annual calendar to be displayed on the staff notice board. See Annexure 136 as an example.

Step 3: In cooperation with the clinic committee seek support from relevant sources.

Step 4: Ensure the necessary communication with stakeholders required for a successful open day.

Step 5: On the day of the event oversee the setup and activities including various health screening.

Step 6: Compile a report of the event including relevant statistics of screenings conducted.

Step 7: Submit the report to the sub-district/district and file the report.

COMPONENT 9: DISTRICT HEALTH SYSTEM SUPPORT

29. District health support

Commitment for Ideal elements 221 - 222

The district supports the facility through Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) to function in line with the national quality standards. The district must provide comprehensive support on all aspects of the management of the facility.

221	***There is a health facility operational plan in line with district health plan***
222	***District PPTICRM visits all facilities at least once a year and those targeted to be Ideal in the specific year at least twice a year to ensure that weaknesses have been corrected and to record the Ideal Clinic Realisation status for the end of year report***

Process

Step 1: Develop a facility operational plan in line with the district health plan. See Annexure 142 that gives guidance on how to develop an operational plan.

Step 2: The PPTICRM, in cooperation with the facility manager, plan and agree on the dates for visits to provide the necessary support to the facility with regard to all the components, sub-components and elements of the Ideal Clinic. See Annexure 143 for a schedule of when the various types of status determinations must be conducted.

Step3: Conduct the status determination and capture the results on the Ideal Clinic software.

Step 4: Using the generated quality improvement plan correct the weaknesses immediately.

Step 5: The status of the facility as well and the corrective actions must be presented at the quarterly district performance review meetings.

30. Emergency patient transport

Commitment for Ideal Clinic elements 223- 227

The facility must have access to emergency medical services (EMS) transport.

223	*There is a pre-determined EMS response time to the facility*
224	*Register for emergency transport request is available*
225	*Remedial action taken when determined EMS response time is not adhered to*
226	*Emergency contact numbers (fire, police, ambulance) are displayed in areas where telephones are available*
227	*SOP available for the handover from facility to EMS*

Process

Step 1: Obtain the norm for the response time relevant to the facility from the sub-district/district Emergency Medical Services (EMS) manager.

Step 2: Keep a register of actual emergency transport response time. See Annexure 144 as an example.

- the staff member requesting patient emergency transport must record the patient details (name, surname, date of birth/age/ID number), date and time patient transport was requested, reason for referral, referral destination, and date and time of patient collection in the ambulance response time
- calculate and record the response times in the register
- on a monthly basis monitor the trend in response time to determine whether the EMS complies with the norm.

Step 3: Verify that the content of the register has been completed in full. See Annexure 145.

Step 4: Escalate to the sub-district/district office if there are consistently long response times or for serious incidents where response time was poor. The district management must communicate the course of redress to the facility.

Step 5: If no response to the follow-up has been received from the sub-district/district office within seven days then escalate the query to the next level.

Note: All corresponded of remedial action taken must be documented, i.e. e-mails, memos etc. sent to the next in line management.

Step 6: Visibly display the contact details of the fire brigade, police station and ambulance in all areas where there are telephones.

Step 7: Develop a SOP that sets out the procedure to hand over patients to EMS staff.

Step 8: Verify that the content of the SOP is aligned with the requirements for the SOP. See Annexure 146.

Step 8: Staff to sign acknowledgment indicating that they are aware and know the content of the SOP and its application. See Annexure 67

Note to reviewers:

- For element 223: The pre-determined response times agreed by the EMS and the District Office must be documented and available within the facility.
- For element 225: Evidence of quarterly reporting to the District Office or sub-district or designated forum will be required in the form of a report or an email sent to the relevant authority. Mark NA where there have been no delays in EMS response times.

31. Referral system

Commitment for Ideal Clinic elements 228 - 231

Facility must have access to a rational and responsive referral system to ensure continuity of care between different levels of health service.

228	***National Referral Policy is available***
229	***District SOP for the referral system is available***
230	***There is a referral register that records referred patients***
231	***Copy of referral letter available in the patient record***

Process

Step 1: Obtain a copy of the National Referral Policy.

Step 2: Obtain a copy of the District SOP for referrals including referral pathways for the facility.

Step 3: Verify that the SOP adheres to the minimum requirements. See Annexure 147.

Step 4: Schedule orientation and training for all healthcare professionals so they know how to refer patients.

Step 5: Make a list of all the referral pathways for the facility as set-out in the SOP and display.

Step 6: Keep sufficient stock of standardised referral forms.

Step 7: Complete the patient referral form when a patient is referred. Hand a copy to the patient and keep a copy in the patient record.

Step 8: Keep record of all referred patients in the referral register. See Annexure 148 as an example.

Step 9: Verify that the referral register has been completed in full. Use Annexure 149.

Step 9: Randomly check whether the referral forms has been completed in full. See Annexure 150.

COMPONENT 10: PARTNERS AND STAKEHOLDERS

32. Partners support

Commitment for Ideal Clinic elements 232 - 233

Implementing partners must support the activities of the facility.

232	***An up to date list of organisations that provide health related services in the catchment area and implementing health partners is available***
233	***The list of implementing health partners shows their areas of focus and business activities***

Process

Step 1: Obtain a list of implementing partners that are operating in the sub-district/district. The list must include their focus and business activities.

Step 2: Compile a list of implementing partners whose focus and business activities is needed by the facility. The list must be updated when details of the health partners change.

Step 3: The sub-district/district schedules an annual meeting in November with all identified health partners to discuss and agree on their contribution to support the facility in the next financial year.

Step 4: The sub-district/district develops and signs a memorandum of understanding on how the support is going to be carried out.

Step 5: The sub-district/district establishes a reporting framework for all implementing partners to the facility and district. See Annexure 151 as an example.

Step 6: The quarterly district review meeting could be used for implementing partners to present their support progress.

Step 7: Compile a list of all the organisation in the facility's catchment area that provide health related services. See Annexure 152 as an example of a template to use to compile the list.

33. Multi-sectoral collaboration

Commitment for Ideal Clinic elements 234

There is continued cooperation and communication between the Provincial Department of Health and the South African Police Service and facilities

234	***There is an official memorandum of understanding between the PDOH and SAPS***

Process

Step 1: Provincial office to develop the memorandum of understanding with SAPS.

Step 2: The responsibilities of SAPS and PDoH must be clearly outlined in the memorandum of understanding. These responsibilities could include but are not limited to:

Responsibilities of the PDoH:

- Ensure that its facilities are secure by providing proper fencing, perimeter lightning, and security guard houses with security guards.
- Ensure that all health facilities have the contact detail of the local SAPS for their respective areas.
- Inform SAPS of any matter that may or have cause a risk to the patients, staff or property of the Department.
- Work together with the SAPS when any matter at the facility need to be investigated.
- Ensure regular communication with the SAPS on a local level through the attendance of multisector forums in respective areas.

Responsibilities of SAP

- To assist the PDoH to ensure the safety of patients, staff and the property of the PDoH when called upon.
- To assist where necessary, if practically possible to monitor security and safety at health facilities by way of regular patrols near health facilities such

as clinics, community health centers and mobile clinics in high risks crime areas.

- To inform the PDoH where security risks have been identified and where necessary advise on measures that would improve the security.
- To investigate reported crime at facilities and to provide feedback to the PDoH in accordance with internal police prescripts.
- To engage the PDoH and relevant stakeholders forums on issues of safety and security at health facilities.
- To provide reasonable access to the SAPS at the workplace without compromising service delivery in order for the PDoH to promote health activities and health service delivery to the employees.
- To invite the SAPS where reasonably possible when organizing internal health promotions and other relevant programmes to ensure maximum benefit to employees.

Step 3: Draft the memorandum of understanding on the province's approved template for memorandum of understandings. See Annexure 153 as an example. The same template can be used for all the memorandum of understanding listed in elements 223 to 238. Replace the purpose and responsibilities of both parties that pertains to the specific memorandum of understanding.

Step 4: Once both parties have agreed on the content of the memorandum of understanding, sign the memorandum of understanding.

Step 5: Distribute memorandum of understanding to district offices and facilities.

Step 6: Orientate facility staff to the contents of the memorandum of understanding.

Step 7: Staff to sign acknowledgment indicating that they are aware of the memorandum of understanding and its application. See Annexure 67.

Step 8: The facility must keep record and provide regular feedback to the sub-district/district on implementation of the memorandum of understanding including consistent lack of cooperation.

Commitment for Ideal Clinic elements 235

There is continued cooperation and communication between the Provincial Department of Health and Department of Education

235 There is an official memorandum of understanding between the PDOH and Department of Education

Process

Step 1: Provincial office to develop the memorandum of understanding with Department of Education.

Step 2: The responsibilities of Department of Education and PDoH must be clearly outlined in the memorandum of understanding. These responsibilities could include but are not limited to:

Responsibilities of the PDoH:

- Ensure that school health services are rendered to the quantile 1 and quantile 2 schools and that the relevant grades are covered by the school health policy.
- Together with Department of Education agree on a roster on when services will be delivered at the relevant schools.
- Provide health promoting activities during school visits or in case of outbreaks
- Keep a record of every child that was assessed at a school.
- Provide feedback to the school after assessments have been completed.
- Refer a child to another level/ service where services cannot be rendered at the school.
- Ensure regular communication with Department of Education through meetings to ensure that services are rendered as required.
- Health facilities to receive and treat referrals from schools.
- In case of outbreaks at schools, visit the school, investigate and ensure that the relevant activities take place to address the matter.
- Ensure that confidentiality is adhered to with regard to the health condition of learners.

Responsibilities of Department of Education

- Provide possible dates for visits to schools and communicate these dates to PDoH, district offices and facilities.
- Provide working space for the school health services to be rendered at a school.
- Ensure that the necessary approval forms were signed by parents prior to visits to school.
- Ensure that the services are arranged in such a manner that the maximum services can be rendered by the team during visits.
- Refer children with problems to the school health service or the local clinic.
- Secure the files of children that were seen by the school health services.
- Inform the local clinic in the event of any outbreak of any disease in the school and provide access to further investigations and treatments.
- Meet with the PDoH and stakeholders to plan for joint activities.
- Ensure confidentiality of health records.
- Organise health promotion and other programmes in conjunction with Department of Health to ensure maximum benefit to staff and communities

Step 3: Draft the memorandum of understanding on the province's approved template for memorandum of understandings.

Step 4: Once both parties have agreed on the content of the memorandum of understanding, sign the memorandum of understanding.

Step 5: Distribute memorandum of understanding to district offices and facilities.

Step 6: Orientate facility staff to the contents of the memorandum of understanding.

Step 7: Staff to sign acknowledgment indicating that they are aware of the memorandum of understanding and its application. See Annexure 67.

Step 8: The facility must keep record and provide regular feedback to the sub-district/district on implementation of the memorandum of understanding including consistent lack of cooperation.

Commitment for Ideal Clinic elements 236

There is continued cooperation and communication between the Provincial Department of Health and Department of Social Services.

236 There is an official memorandum of understanding between the PDOH and the Department of Social Development

Process

Step 1: Provincial office to develop the memorandum of understanding with Department of Social Services.

Step 2: The responsibilities of Department of Social Services and PDoH must be clearly outlined in the memorandum of understanding. These responsibilities could include but are not limited to:

Responsibilities of the PDoH:

- Render services in line with the Primary Health care re-engineered approach where ward base teams will be the extension of health services at a community level.
- Quality health services to be delivered at the health facility in line with the Ideal clinic standards.
- Refer patients to Social development where aspects are identified by the clinic or ward based services which need intervention from Social development.
- Meet on a regular basis at Provincial and local level to ensure a smooth working relationship with Department of Social Development.
- Organise health promotion and other programmes in conjunction with Department of Social Development to ensure maximum benefit to the communities.
- Monitor and communicate with Social development population health indicators that are affected by the mandate of social development.

Responsibilities of Department of Social Services

- Cooperate with the PDoH to ensure a coordinated community-based service.
- Will meet with the PDoH regularly to ensure that there is cooperation between the facility and Social Services.
- Social Development to ensure staff that services the respective area follow-up on referrals from the clinic.
- Channel health related referrals to the relevant ward base team or clinic.
- Work with PDoH to ensure a coordinated approach regarding programmes to enhance the service/
- Co-operate with PDoH in an annual joint quality assurance assessment of Old Age Homes and Children Homes.
- Train health staff on relevant Social Development programs.
- Provide access to support grants.
- Provide access to the PDoH for health promotion activities and health service delivery to staff where applicable.
- Organise health promotion and other programmes in conjunction with PDoH to ensure maximum benefit to staff and communities.

Step 3: Draft the memorandum of understanding on the province's approved template for memorandum of understandings.

Step 4: Once both parties have agreed on the content of the memorandum of understanding, sign the memorandum of understanding.

Step 5: Distribute memorandum of understanding to district offices and facilities.

Step 6: Orientate facility staff to the contents of the memorandum of understanding.

Step 7: Staff to sign acknowledgment indicating that they are aware of the memorandum of understanding and its application. See Annexure 67.

Step 8: The facility must keep record and provide regular feedback to the sub-district/district on implementation of the memorandum of understanding including consistent lack of cooperation.

Commitment for Ideal Clinic elements 237

There is continued cooperation and communication between the Provincial Department of Health and Department of Public Works.

237 There is an official memorandum of understanding between the PDOH and Department of Public Works

Process

Step 1: Provincial office to develop the memorandum of understanding with Department of Public Works.

Step 2: The responsibilities of Department of Public Works and PDoH must be clearly outlined in the memorandum of understanding. These responsibilities could include but are not limited to:

Responsibilities of the PDoH:

- Provide information to Department of Roads and Public works where new facilities are planned, upgrades and refurbishment are required.
- Inform Department of Roads and Public Works when the condition of roads makes it impossible to deliver services.
- Communicate with Department of Roads with relation to the need for road signage to health facilities from major access routes.
- Ensure that properties are well maintained and report shortcomings to public works.

Responsibilities of Department of Public Works

- Ensure that there are proper roads to health facilities.
- Ensure that roads are in good condition for health personnel and community to have health facility access.
- Ensure the safety of roads to limit motor vehicle accidents.
- Provide signage to health facilities from major access roads.

- Oversee capital building projects of the Department to ensure that it is in line with the needs of the Department.
- Ensure quality in the building process of facilities for the PDoH.
- Keep an immovable asset register of all properties of the PDoH
- Do the payments of all rates and taxes on PDoH's buildings
- Ensure regular maintenance of buildings.
- Ensure land acquisition for new facilities
- Provide access to the PDoH for health promotion activities and health service delivery to staff where applicable.
- Organise health promotion and other programmes in conjunction with PDoH to ensure maximum benefit to staff and communities.

Step 3: Draft the memorandum of understanding on the province's approved template for memorandum of understandings.

Step 4: Once both parties have agreed on the content of the memorandum of understanding, sign the memorandum of understanding.

Step 5: Distribute memorandum of understanding to district offices and facilities.

Step 6: Orientate facility staff to the contents of the memorandum of understanding.

Step 7: Staff to sign acknowledgment indicating that they are aware of the memorandum of understanding and its application. See Annexure 67.

Step 8: The facility must keep record and provide regular feedback to the sub-district/district on implementation of the memorandum of understanding including consistent lack of cooperation.

Commitment for Ideal Clinic elements 238

There is continued cooperation and communication between the Provincial Department of Health and Department of Transport.

238 There is an official memorandum of understanding between the PDOH and Department of Transport

Process

Step 1: Provincial office to develop the memorandum of understanding with Department of Transport.

Step 2: The responsibilities of Department of Transport and DoH must be clearly outlined in the memorandum of understanding. These responsibilities could include but are not limited to:

Responsibilities of the PDoH:

- Work with the Department of Transport, Safety and Liaison to ensure campaigns preventing injuries and accidents.
- Liaise closely with the Department of Transport, Safety and Liaison to assist with crime prevention and control in and around the health facilities.
- Take all health vehicles on a regular base for Road worthy testing to ensure safe vehicles.
- Ensure that all PDoH vehicles are licensed.
- Provide information to Department of Transport on areas where public transport may be needed to make health facilities more accessible.

Responsibilities of Department of Transport:

- Facilitate and coordinate social crime prevention and road safety programmes and thus reduce accidents and injury.
- Coordinate crime prevention and community safety partnerships and thus influencing safety at health facilities.

- Coordinate licensing and road worthiness of vehicles and thus also ensuring safety of PDoH vehicles.
- Communication and awareness of Road safety Campaigns.
- Provide access to the PDoH for health promotion activities and health service delivery to staff where applicable.
- Organise health promotion and other programmes

Step 3: Draft the memorandum of understanding on the province's approved template for memorandum of understandings.

Step 4: Once both parties have agreed on the content of the memorandum of understanding, sign the memorandum of understanding.

Step 5: Distribute memorandum of understanding to district offices and facilities.

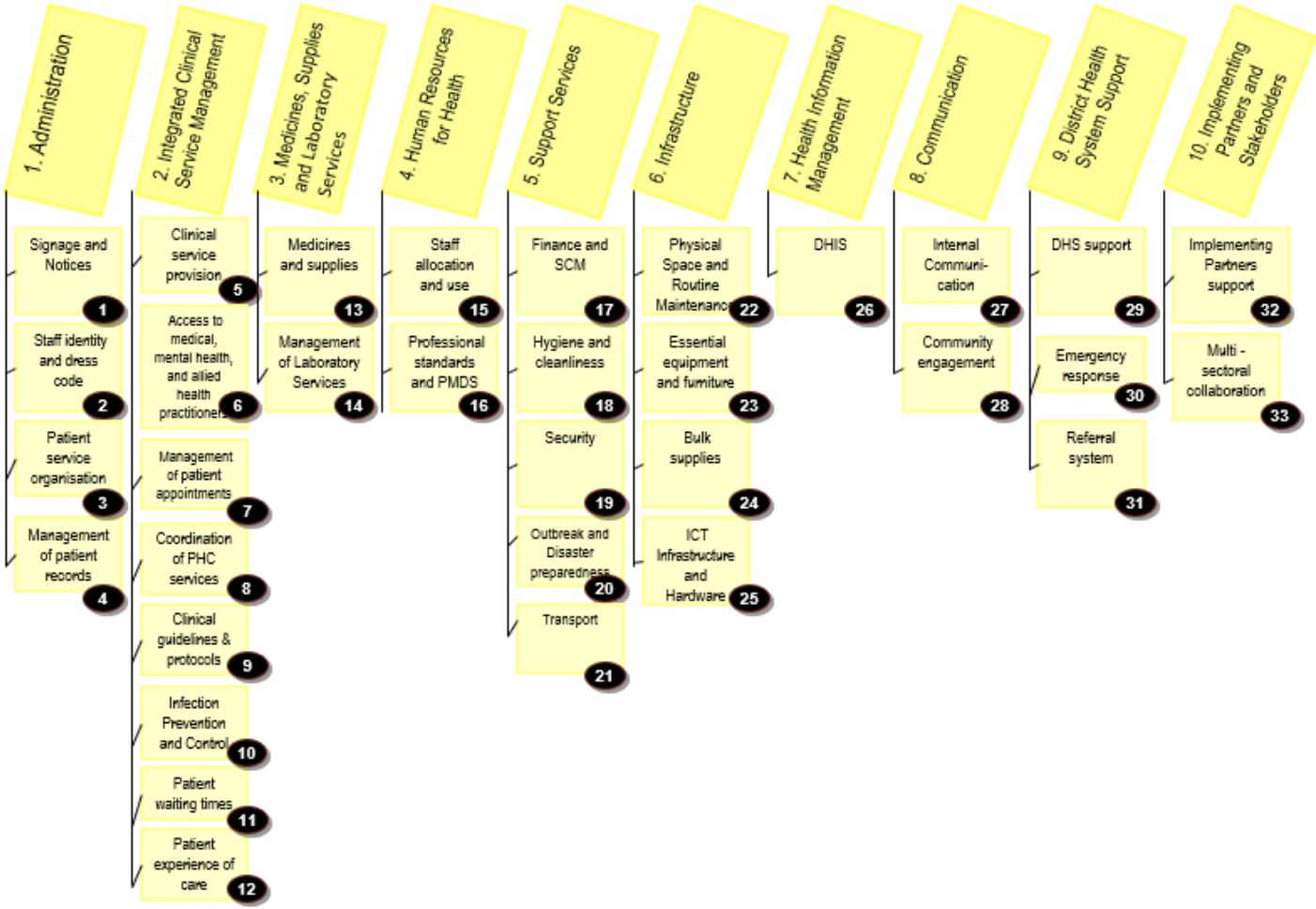
Step 6: Orientate facility staff to the contents of the memorandum of understanding.

Step 7: Staff to sign acknowledgment indicating that they are aware of the memorandum of understanding and its application. See Annexure 67.

Step 8: The facility must keep record and provide regular feedback to the sub-district/district on implementation of the memorandum of understanding including consistent lack of cooperation.

Annexure 1: Components and sub-component of Ideal Clinic dashboard, version 19

10 Components and 33 Sub-Components



Annexure 2: Ideal Clinic Realisation and Maintenance Framework, version 19

This document/tool contains a carefully selected set of elements that speaks to quality and safety. The tool is to be used to determine the status of a health facility's performance against these elements.

Colour coding of text:

Text coloured in green indicates the elements that will be regulated according to the Norms and Standards Regulations applicable to different categories of health establishments.

Key and description for method of measurement

Key	Method of measurement (MM)
□	a) Check applicable documents e.g. policies, guidelines, SOP, data, etc.
?	b) Ask staff members and/or clients for their views or level of understanding
□	c) Objective observations and/or conclusion
□	d) Test the functionality of equipment/systems

Key and description for level of responsibility

Key	Description
NDoH	National Department of Health
P	Province
D	District
HF	Health facility

Key and description for weights

Key	Description
NNV	Non-negotiable Vitals
V	Vital
E	Essential
I	Important

Performance is scored in line with two colours as follows:

Green = Achieved (Yes)

Red = Not achieved (No)

For elements without a checklist

Binary scoring: 1 or 0

Achieved (**Green**): Yes = 1

Not-achieved (**Red**): No = 0

For elements without a checklist

Fractional scoring: e.g. 10/20 measures compliant on checklist, score = 0.5

Achieved (**Green**): NNV = 1; V ≥ 0.8; E ≥ 0.6; I ≥ 0.5

Not-achieved (**Red**): NNV <1; V < 0.8; E < 0.6; I < 0.5

Weighting of the Ideal Clinic elements

The Ideal Clinic elements are weighted according to three categories: vital, essential and important.

Definition of weigh categories

Non-negotiable vitals

These are elements that can cause loss of life or prolonged period of recovery.

Vital

Extremely important (vital) elements that require immediate and full correction. These are elements that affect direct service delivery to and clinical care of patients and without which there may be immediate and long-term adverse effects on the health of the population.

Essential

Very necessary (essential) elements that require resolution within a given time period. These are process and structural elements that indirectly affect the quality and safety of clinical care given to patients.

Important

Significant(important) elements that require resolution within a given time period. These are process and structural elements that affect the quality of the environment in which healthcare is given to patients.

Ideal Clinic realisation and maintenance: Components, sub-components and elements (Version 19)

Component	Sub-component		ELEMENTS	Weight	MM	Level of responsibility	Check list	Performance
1. Administration	**1. Signage and notices:** Monitor whether there is communication about the facility and the services provided							
		1	All external signage in place	I	😐	P	**Y**	
		2	Facility information board displayed at the entrance of the premises reflects relevant information for the facility	E	😐	D	**Y**	
		3	Disclaimer sign is clearly sign posted at the entrance of the facility	E	😐	D	**Y**	
		4	Vision, mission and values of the province/district are visibly displayed	I	😐	D		
		5	Facility organogram with contact details of the facility manager is displayed on a central notice board	I	😐	HF		
		6	Patients' Rights Charter is displayed in all waiting areas in at least two local languages	I	😐	HF		
		7	All service areas within the facility are clearly signposted	E	😐	HF	**Y**	
	2. Staff identity and dress code: Monitor whether staff uniform, protective clothing and mode of staff identification are in accordance with policy prescripts							
		8	There is a prescribed dress code for all service providers	I	🕮	P		
		9	All healthcare professional staff members comply with prescribed dress code	I	?😐	HF	**Y**	
		10	All staff members wear an identification tag	I	😐	HF	**Y**	
	3. Patient service organisation: Monitor the processes that enable responsive patients service							
		11	Sign posted help desk/reception services are available	E	😐🕮	HF		
		12	There is a process that prioritises the very sick, frail and elderly patients	V	?🕮	HF	**Y**	
		13	A functional wheelchair is available	E	?😐	HF		
	4. Management of patient record: Monitor whether patient records content is organised according to Integrated Clinical Services Management (ICSM) prescripts, whether the prescribed stationery is used and whether patient records are managed appropriately							
		14	There is a single patient record irrespective of health conditions	I	😐🕮	HF		
		15	Patient record content adheres to ICSM prescripts	V	😐🕮	HF	**Y**	
		16	District/provincial SOP/guideline for filing, archiving and disposal of patient records is available	E	🕮	P	**Y**	
		17	District/provincial SOP/ guideline for filing, archiving and disposal of patient records is adhered to	E	😐	HF	**Y**	
		18	There is a single location for storage of all active patient records	I	😐	HF		

		19	Patient records are filed close to patient registration desk	I	?😐	HF		
		20	Retrieval of a patient's file takes less than 10 minutes	I	?😐	HF		
		21	Records are not left unattended in public areas and are only accessible to facility staff and patients	V	😐	HF		
		22	Records are not left unattended in clinical service areas	E	😐	HF		
		23	Priority stationery (clinical and administrative) is available at the facility in sufficient quantities	I	🕮	HF	Y	
2. Integrated Clinical Services Management (ICSM)	**5. Clinical service provision:** Monitor whether clinical integration of clinical care services allowing for three discrete streams (acute, chronic and MCWH) of service delivery is adhered to as per service package and whether this results in improvements in key population health and service indicators							
		24	Facility has been reorganised with designated consulting areas and staffing for acute, chronic health conditions and preventative health services.	E	😐	HF		
		25	Patients are consulted, examined and counselled in privacy	I	😐	HF		
		26	TB treatment success rate is at least 87% or has increased by at least 5% from the previous year	E	🕮	HF		
		27	TB (new pulmonary) defaulter rate < 5%	E	🕮	HF		
		28	Antenatal visit rate before 20 weeks gestation is at least 70% or has increased by at least 5% from the previous year	E	🕮	HF		
		29	Antenatal patient initiated on ART rate is at least 97% or has increased by at least 5% from the previous year	E	🕮	HF		
		30	Immunisation coverage under one year (annualised) is at least 86% or has increased by at least 5% from the previous year	E	🕮	HF		
		31	Quality Improvements plans are signed off by the facility manager and updated quarterly	E	🕮	HF	Y	
		32	Six monthly district/sub-district clinical performance review report with action plan from clinical quality supervisors are available	E	🕮	D		
	6. Access to medical, mental health, allied health practitioners, pharmacists and adolescent friendly services: Monitor patient and staff access to clinical expertise at PHC level							
		33	Patients that require consultation with a medical practitioner have access to a medical practitioner at the facility at least once a week.	E	🕮	HF		
		34	Patients have access to oral health services	I	🕮	D		
		35	Patients have access to occupational therapy services	I	🕮	D		
		36	Patients have access to physiotherapy services	I	🕮	D		
		37	Patients have access to dietetic services	I	🕮	D		
		38	Patients have access to social work services	I	🕮	D		
		39	Patients have access to radiography services	I	🕮	D		
		40	Patients have access to ophthalmic service	I	🕮	D		
		41	Patients have access to mental health services	E	🕮	D		
		42	Patients have access to speech and hearing services	I	🕮	D		
		43	Staff authorised to dispense medicine have access to the support of a pharmacist	I	🕮	D		
		44	Adolescent and Youth Friendly Health Services are provided	I	🕮	D	Y	
	7. Management of patient appointments: Monitor whether an ICSM patient appointment system is adhered to							

		45	ICSM compliant patient appointment system for patients with chronic health conditions and MCWH patient is in use	I	🕮	HF		
		46	Records of booked patients are retrieved not later than the day before the appointment	I	😐	HF		
		47	Pre-dispensed medication for clinically stable chronic patients is prepared for collection not later than the day before collection date or patients are enrolled on the CCMDD/CDU programme	E	? 😐	HF		
2. Integrated Clinical Services Management (ICSM)	**8. Coordination of PHC services:** Monitor whether there is coordinated planning and execution between PHC facility, School Health Team, community-based and environmental health services							
		48	Facility does referrals to and receives referrals from school health services in its catchment area	I	🕮	D		
		49	Facility refers patients with chronic but stable health conditions to home- and community-based services for support	E	🕮	HF		
		50	Facility refers environmental health related risks to environmental health services	I	🕮	D	**Y**	
	9. Clinical guidelines and protocols: Monitor whether clinical guidelines and protocols are available, whether staff have received training on their use and whether they are being appropriately applied							
		51	ICSM compliant package of clinical guidelines is available in all consulting rooms	E	🕮	HF	**Y**	
		52	National guidelines on priority health conditions are available	E	🕮	HF	**Y**	
		53	80% of professional nurses have been fully trained on Adult Primary Care OR Practical Approach to Care Kit	E	🕮	D		
		54	80% of professional nurses have been fully trained on Integrated Management of Childhood Illness	E	🕮	D		
		55	Resuscitation protocol is available	E	🕮	HF		
		56	SOP for informed consent available	E	🕮	HF	**Y**	
		57	80% of professional nurses have been trained on Basic Life Support	V	🕮	D		
		58	50% of professional nurses at the facility are trained on BANC Plus	E	🕮	D		
		59	National Guideline for Patient Safety Incident Reporting and Learning is available	E	🕮	NDoH		
		60	Facility/district SOP for Patient Safety Incident Reporting and Learning is available	E	🕮	HF	**Y**	
		61	Patient safety incident records comply with the National Guideline for Patient Safety Incident Reporting and Learning	V	🕮	HF	**Y**	
		62	All SAC 1 adverse events are reported to the next level of management within 24 hours	V	🕮	HF		
		63	National Clinical Audit Guideline is available	E	🕮	NDoH		
		64	Clinical audits are conducted annually on priority health conditions	E	🕮	HF	**Y**	
		65	80% of patient records audited are compliant	E	🕮	HF	**Y**	
		66	Clinical audit meetings are conducted quarterly in line with the guidelines	E	🕮	HF		
		67	National guidelines are followed for all notifiable medical conditions	V	?🕮	HF	**Y**	
		68	SOP for the management of patients with highly infectious diseases is available	V	🕮	HF	**Y**	

2. Integrated Clinical Services Management (ICSM)	**10. Infection prevention and control:** Monitor adherence to prescribed infection prevention and control policies and procedures							
	69	National Infection Prevention and Control strategic framework is available	E	🕮	NDoH		
	70	Facility has a designated staff member who is responsible for infection prevention and control	E	🕮	HF		
	71	SOP for standard precautions is available	V	🕮	HF	**Y**	
	72	All staff have received in-service training in the past two years on standard precautions that is inline with the SOP	V	🕮	HF	**Y**	
	73	Posters on hand hygiene is displayed	I	🕮	HF	**Y**	
	74	Awareness day on hand hygiene is held annually	V	🕮	HF		
	75	Poster on cough etiquette is displayed in every waiting area	I	🕮	HF		
	76	Staff wear appropriate protective clothing	V	?😐	HF	**Y**	
	77	The linen in use is sufficient, clean, appropriately used and not torn	E	😐	HF	**Y**	
	78	Dirty, soiled and infectious linen are collected in a wheeled cart or trolley	I	😐	HF		
	79	Sharps are disposed of appropriately	V	😐	HF	**Y**	
	80	An annual risk assessment for infection prevention and control compliance is conducted	I	🕮	HF		
	81	All staff are made aware of the provincial letter/memo/circular that inform staff of the procedure to follow for prophylactic immunisations	E	🕮	HF	**Y**	
	11. Patient waiting time: Monitor adherence to the facility's prescribed waiting times							
	82	National Guideline for the Management of Waiting Times is available	I	🕮	NDoH		
	83	National target of not more than three hours for time spent in a facility is visibly displayed	E	😐🕮	HF		
	84	Waiting time tools to record waiting time is available	E	🕮	HF		
	85	Waiting time survey report is available	E	🕮	HF		
	86	Average time that a patient spends in the facility is no longer than 3 hours	E	🕮	HF		
	12. Patient experience of care: Monitor whether an annual patient experience of care survey is conducted and whether patients are provided with an opportunity to complain about or compliment the facility and whether complaints are managed within the prescribed time							
	87	National Patient Experience of Care Guideline is available	E	🕮	NDoH		
	88	Results of the annual Patient Experience of Care Survey are visibly displayed at the main waiting area	E	🕮	HF	**Y**	
	89	An average overall score of 80% is obtained in the Patient Experience of Care Survey	E	🕮	HF		
	90	National Guideline to Manage Complaints/Compliments/Suggestions is available	E	🕮	NDoH		
	91	Complaints/compliments/suggestions toolkit is available at the main entrance/exit	E	😐	HF	**Y**	
	92	Complaints/compliments/suggestions records complies with the National Guideline to Manage Complaints/Compliments/Suggestions	E	🕮	HF	**Y**	
	93	Targets set for complaints indicators are met	E	🕮	HF	**Y**	
3.	**13. Medicines and supplies: Monitor consistent availability of required good quality medicines and supplies**							
	94	There is a 'No unauthorised entry' sign on the door	E	😐	HF		

3. Pharmaceuticals and Laboratory Services		95	SOP for the management of availability of medicines is available	E	🕮	HF	**Y**	
		96	Hand hygiene facilities are available	V	😐	HF	**Y**	
		97	Cleaning schedule for the Medicine room/dispensary is available	E	🕮	HF		
		98	Cleaning is carried out in accordance with the schedule	V	🕮	HF		
		99	All work completed is signed off by cleaners and verified by manager or delegated staff member	E	🕮	HF		
		100	Medicine room/dispensary and waiting area are clean	V	😐	HF	**Y**	
		101	Medicine room/dispensary is neat and medicines are stored to maintain quality	I	😐	HF	**Y**	
		102	The temperature of the medicine room/dispensary is maintained within the safety range	V	🕮	HF	**Y**	
		103	Cold chain procedure for vaccines is maintained	V	🕮	HF	**Y**	
		104	Medicine cupboard or trolley is neat and orderly	I	😐	HF	**Y**	
		105	The register for schedule 5 and 6 medicines is completed correctly	V	🕮	HF		
		106	Schedule 5 and 6 medicine in stock correspond with the balance recorded in the register	V	🕮	HF		
		107	Electronic networked system for monitoring the availability of medicines is used effectively	E	😐🕮	HF	**Y**	
		108	Stock take conducted in the medicine room/dispensary in past 12 months	V	🕮	HF		
		109	Medicines on the tracer medicine list are available	V	😐🕮	HF	**Y**	
		110	Re-ordering stock levels (min/max) are determined for each item on the district/facility formulary	V	😐🕮	HF		
		111	There is no expired medicine on the shelves	V	😐	HF		
		112	Waste receptacles for pharmaceutical waste are available	V	😐	HF		
		113	Health care waste is managed appropriately	E	😐	HF	**Y**	
		114	Expired medicine is disposed of according to prescribed procedures	E	**?**	HF		
		115	Basic medical supplies (consumables) are available	V	🕮	HF	**Y**	
	14. Management of laboratory services: Monitor consistent availability and use of laboratory services							
		116	Primary Health Care Laboratory Handbook is available	E	🕮	NDoH		
		117	Required functional diagnostic equipment and concurrent consumables for point of care testing are available	V	😐	HF	**Y**	
		118	Required specimen collection materials and stationery are available	V	😐	HF	**Y**	
		119	Specimens are collected, packaged, stored and prepared for transportation according to the Primary Health Care Laboratory Handbook	E	😐	HF	**Y**	
		120	Laboratory results are received from the laboratory within the specified turnaround times	E	🕮	HF	**Y**	
		121	Facility is enrolled as testing point in the NHLS HIV- Proficiency Testing scheme	I	🕮	HF		
		122	Facility controls rapid test kit performances by running one negative and one positive control on a weekly basis	E	🕮	HF		

4. Human Resources for Health	**15. Staff allocation and use:** Monitor whether the PHC facility has the required HRH capacity and whether staff are appropriately applied							
		123	Staffing needs have been determined in line with workload requirements	V	?🕮	D		
		124	Staff appointed in line with determined requirements	V	🕮	D	**Y**	
		125	Facility has a dedicated manager	E	🕮	D		
		126	Work allocation schedule is signed by all staff members	I	🕮	HF		
		127	Leave policy is available	I	🕮	D		
		128	An annual leave schedule is available	I	🕮	HF		
	16. Professional standards and Performance Management Development System (PMDS): Monitor whether staff are managed according to Department of Public Service Administration (DPSA) and Department of Labour prescripts							
		129	Record of staff induction is available	I	🕮	HF		
		130	All healthcare workers have current registration with relevant professional bodies	V	🕮	HF	**Y**	
		131	Performance Management guidelines are adhered to	E	🕮	HF	**Y**	
		132	Continued staff development needs are determined for the current financial year and submitted to the district manager	I	🕮	HF		
		133	Training records reflect planned training is conducted as per the district training programme	I	🕮	HF		
		134	The disciplinary procedure is available	I	🕮	HF		
		135	The grievance procedure is available	I	🕮	HF		
		136	Staff satisfaction survey is conducted annually	I	🕮	D		
		137	The results of the staff satisfaction survey are used to improve the work environment	I	🕮	HF		
		138	SOP for management of occupational health and safety incidents is available	E	🕮	HF	**Y**	
		139	Health and Safety representative appointed (NA is staff establishment is less than 20 staff members)	E	🕮	HF		
		140	Health and Safety committee appointed (NA if less than 2 safety reps)	E	🕮	HF		
		141	Occupational Health and Safety incidents are managed and recorded in a register	E	🕮	HF	**Y**	
		142	Occupational health and safety risk assessment has been conducted in the past two years	E	🕮	HF		
		143	Risk mitigation interventions are implemented for identified occupational health and safety risks	E	🕮	HF		
5.	**17. Finance and supply chain management:** Monitor the consistent availability of a functional supply chain management system as well as the availability of funds required for optimal service provision							
		144	Facility has a dedicated budget	I	🕮	D		
		145	Facility has a SOP for obtaining general supplies	E	🕮	HF		
	18. Hygiene and cleanliness: Monitor whether the required systems and procedures are in place to ensure consistent cleanliness in and around a facility							
		146	All cleaners have been trained on cleaning procedures	V	🕮	HF		
		147	Cleaning schedules are available for all areas in the facility	E	🕮	HF		

5. Support		148	Cleaning is carried out in accordance with the schedule	V	🕮	HF		
		149	Disinfectant, cleaning materials and equipment are available	V	🕮	HF	Y	
		150	All work completed is signed off by cleaners and verified by manager or delegated staff member	E	🕮	HF	Y	
		151	All service areas are clean	V	😐	HF	Y	
		152	Hand hygiene facilities are available	V	😐	HF	Y	
		153	SOP for managing health care waste is available	V	🕮	HF	Y	
		154	Health care waste is managed appropriately	V	?😐	HF	Y	
		155	Central storage area for health care waste is appropriate	V	😐	D	Y	
		156	All toilets are clean, intact and functional	V	?😐	HF	Y	
		157	Exterior of the facility is clean and well maintained	E	😐	HF	Y	
		158	Signed waste removal service level agreement between the health department and the service provider is available	E	🕮	P		
		159	Health care risk waste is removed in line with the service level agreement	V	?🕮	HF		
		160	The service level agreement for waste removal and disposal of waste is monitored	E	🕮	HF		
		161	Breaches in waste removal contract are escalated to the relevant authority	E	🕮	HF		
		162	Records show that pest control is done according to schedule	V	🕮	HF		
	19. Security: Monitor whether systems processes, procedures are in place to protect the safety of assets, infrastructure, patients and staff of the PHC facility							
		163	Safety and security SOP is available	E	🕮	HF	Y	
		164	Perimeter fencing is intact	I	😐	HF		
		165	Parking for staff is provided on the facility premises	I	😐	D		
		166	There is a standard security guard room OR the facility has an alarm system linked to armed response	I	😐	D	Y	
		167	There is a security guard on duty OR the facility has an alarm system linked to armed response	I	😐	D		
		168	Security services rendered according to contract OR provincial security policy/facility SOP	E	😐🕮	HF	Y	
		169	A signed copy of the service level agreement between the security company and the provincial department of health is available	E	?🕮	D		
		170	Security breaches are managed and recorded in a register	E	🕮	HF	Y	
	20. Outbreak and Disaster preparedness: Monitor whether firefighting equipment is available and whether staff know how to use it and whether disaster drills are conducted							
		171	Functional firefighting equipment is available	V	😐👆	D	Y	
		172	Evacuation plan is displayed in the manager's office and the main entrance	I	🕮	HF		
		173	Contact numbers of healthcare personnel required in emergencies are available in the management offices and at reception	I	🕮	HF		
		174	Emergency evacuation procedure is practised annually	E	🕮	HF		
		175	Deficiencies identified during the practice of the emergency evacuation drill are addressed	E	🕮	HF		
		176	SOP for outbreak notification and response are available	E	🕮?	HF		

5. Support	**21. Transport: Monitor whether staff and patients are transported safely**							
	177	All official vehicles used to render services or transport patients are licensed annually	E	🕮	D		
	178	All official vehicles used to render services or transport patients are serviced according to manufacturer's schedule	E	🕮	D		
	179	All staff driving official vehicles to render services or transport patients have a valid driver's license	E	🕮	D		
	180	All staff driving official vehicles to render services or transport patients have a valid professional driving permits where applicable	E	🕮	D		
6. Infrastructure	**22. Physical space and routine maintenance:** Monitor whether the physical space is adequate for the PHC facility workload, disabled persons and whether timely routine maintenance is undertaken							
	181	Clinic space accommodates all services and staff	E	😐🕮	D	Y	
	182	Clinical service areas have natural ventilation or functional mechanical ventilation	V	😐	D	Y	
	183	There is access for people in wheelchairs	E	😐	D	Y	
	184	Maintenance schedules for building (s) and grounds are available	V	🕮	D		
	185	Building(s) is maintained according to schedule	E	😐🕮	D	Y	
	186	Building(s)complies with safety regulations	V	🕮	D	Y	
	23. Essential equipment and furniture: Monitor whether essential equipment and required furniture are available							
	187	Furniture is available and intact in service areas	I	😐	HF	Y	
	188	Essential equipment is available and functional in consulting areas	V	😐	HF	Y	
	189	Staff are trained on the use of essential equipment	E	🕮	HF		
	190	SOP for reactive maintenance of medical equipment is available	I	🕮	HF		
	191	Maintenance plan for essential equipment is adhered to	E	🕮	HF		
	192	Resuscitation room is equipped with functional, basic resuscitation equipment	V	😐🕮	HF	Y	
	193	Emergency trolley is restored daily or after each use	NNV	😐🕮	HF	Y	
	194	There is an emergency sterile obstetric delivery pack	V	😐	HF	Y	
	195	There is a sterile pack for minor surgery	V	😐	HF	Y	
	196	Functional oxygen cylinder with pressure gauge is available in resuscitation/ emergency room	NNV	😐	HF		
	197	Oxygen available in the cylinder is above the minimum level	NNV	😐	HF		
	198	Imaging service unit is accredited	E	🕮	HF		
	199	An up-to-date asset register is available	I	😐🕮	HF	Y	
	200	Redundant and non-functional equipment is removed from the facility	I	😐	HF		
	24. Bulk supplies: Monitor whether the required electricity supply, water supply and sewerage services are constantly available							
	201	Facility has a functional piped potable water supply	V	?👎	D		
	202	Facility has access to emergency water supply when needed	V	👎😐	D		
	203	Facility has access to a functional back-up electrical supply when needed	V	?😐	D	Y	
	204	Sewerage system is functional	V	👎😐	D		
	25. ICT infrastructure and hardware: Monitor whether systems for internal and external electronic communication are available and functional							
	205	There is a functional telephone in the facility	E	?👎	D		

		206	There is a functional computer	I	?👂	HF		
		207	There is functional printer connected to the computer	I	?👂	HF		
		208	There is internet access	I	?👂	D		
7. Health Information	**26. District Health Information System (DHIS):** Monitor whether there is an appropriate information system that produces information for service planning and decision making							
		209	Facility performance in response to burden of disease of the catchment population is displayed and is known to all clinical staff members	I	?😐	HF		
		210	National District Health Information Management System policy OR Provincial SOP aligned with National Policy is available	I	🕮	HF		
		211	Clinical personnel and data capturer trained on the facility level Standard Operating Guidelines for Data Management	I	🕮	HF		
		212	Relevant DHIS registers are available and are kept up to date	I	?😐	HF		
		213	Facility submits all monthly data on time to the next level	I	🕮	HF		
		214	There is a functional computerised patient information system	I	?👂	D		
8. Communication	**27. Internal communication:** Monitor whether the communications system required for improved quality for service delivery is in place							
		215	There are sub-district/district quarterly facility performance review meetings	I	🕮	D		
		216	A staff meeting is held at least quarterly within the facility	I	🕮	HF		
		217	Staff members demonstrate that incoming policies/guidelines/SOPs/ notices have been read and are understood by appending their signatures on such policies/guidelines/SOPs/notifications	E	🕮	HF	Y	
	28. Community engagement: Monitor whether the community participates in PHC facility activities through representation in a functional clinic committee							
		218	There is a functional clinic committee	E	🕮	P	Y	
		219	Contact details of clinic committee members are visibly displayed	I	😐	HF		
		220	Facility hosts an annual open day	I	🕮	HF		
9. District Health System Support	**29. District Health Support (DHS):** Monitor the support provided to the facility through guidance from district management, regular Ideal Clinic status measurement by the PPTICRM as well as through visits from the district support and health programme managers							
		221	There is a health facility operational plan in line with district health plan	I	🕮	HF		
		222	District PPTICRM visits all facilities at least once a year and those targeted to be Ideal in the specific year at least twice a year to ensure that weaknesses have been corrected and to record the Ideal Clinic Realisation status for the end of year report	E	?🕮	D		
	30. Emergency response: Monitor the effectiveness of emergency responses							
		223	There is a pre-determined EMS response time to the facility	E	?🕮	D		
		224	Register for emergency transport requests is available	E	🕮	D	Y	
		225	Remedial action taken when predetermined EMS response time is not adhered to	E	🕮	D		
		226	Emergency contact numbers (fire, police, ambulance) are displayed in areas where telephones are available	V	🕮	HF		
		227	SOP available for the handover between facility and EMS	E	🕮	HF	Y	
	31. Referral system: Monitor whether patients have access to appropriate levels of healthcare							
		228	National Referral Policy is available	I	🕮	NDoH		
		229	District SOP for the referral system is available	E	🕮	HF	Y	
		230	There is a referral register that records referred patients	E	🕮	HF	Y	
		231	Copy of referral form available in the patient record	E	🕮	HF	Y	

10. Implementing Partners and Stakeholders	**32. Implementing partners support:** Monitor the support that is provided by implementing partners						
	232	An up to date list of all organisations that provide health related services in the catchment area and implementing health partners is available	I	🕮	HF		
	233	The list of implementing health partners shows their areas of focus and business activities	I	?🕮	HF		
	33. Multi-sectoral collaboration: Monitor the systems in place to respond to the social determinants of health						
	234	There is an official memorandum of understanding between the PDOH and SAPS	I	🕮	P		
	235	There is an official memorandum of understanding between the PDOH and Department of Education	I	🕮	P		
	236	There is an official memorandum of understanding between the PDOH and the Department of Social Development	I	🕮	P		
	237	There is an official memorandum of understanding between the PDOH and Department of Public Works	I	🕮	P		
	238	There is an official memorandum of understanding between the PDOH and Department of Transport	I	🕮	P		

Summary of Ideal Clinic categories

Weights	Silver	Gold	Platinum
Non-negotiable Vitals (3 elements)	100%	100%	100%
Vital (53 elements)	60-69%	70-79%	≥80%
Essential (104 elements)	50-59%	60-69%	≥70%
Important (78 elements)	50-59%	60-69%	≥70%

Annexure 3: Checklist for element 1 - External signage in place

Use the checklist below to check the facility's external signage

Scoring – in column for score mark as follows:

Y (Yes) = present; **N** (No) = not present; **NA** (Not applicable) = for small facilities or where certain services are not rendered

External signage	**Score**
Geographical location signage from main roads	
a. Both directions on each main road	
b. Within 1 km of clinic	
c. No obstructions to visibility	
Facility gate entrance signage	
a. Vehicles and persons will be searched	
b. Entry and parking are at own risk	
Specific external locations:	
a. Emergency Assembly Point	
Waste storage:	
a. Healthcare Risk Waste (medical waste)	
b. Healthcare General Waste	
At or near to main entrance of building:	
a. Ambulance parking sign OR area marked on paving	
b. Disabled parking sign OR area marked on paving	
Total score	
Total maximum possible score (sum of all scores minus those marked NA)	
Percentage (Total score ÷ Total maximum possible score) x 100	**%**

Annexure 4: Checklist for element 2 - Facility information board displayed at the entrance of the facility reflects relevant information for the facility

Use the checklist below to check the facility's information board

Scoring - in column for score mark as follows:

Y (Yes) = if present, **N** (No) = if not present

Information	Score
Facility's name	
Service hours of the facility	
Physical address of the facility	
Contact details of the facility	
Contact details of the emergency services	
Service package	
Total	
Score (Total ÷ 6)	

Annexure 5: Checklist for element 3 – Disclaimer sign is clearly sign posted at the entrance of the facility

Use the checklist below to check whether the disclaimer sign of the facility displays the disclaimers as indicated

Scoring - in column for score mark as follows:

Y (Yes) = if present, **N** (No) = if not present

Information	**Score**
No weapons	
No smoking	
No animals (except for service animals)	
No littering	
No Hawkers	
Total	
Score (Total ÷ 5)	

Annexure 6: Patient's Rights Charter

The Patients' Rights Charter

For many decades the vast majority of the South African population has experienced either a denial or violation of fundamental human rights, including rights to health care services. To ensure the realisation of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa (Act No 108 of 1996), the Department of Health is committed to upholding, promoting and protecting this right and therefore proclaims this **PATIENTS' RIGHTS CHARTER** as a common standard for achieving the realisation of this right.

This Charter is subject to the provisions of any law operating within the Republic of South Africa and to the financial means of the country.

A healthy and safe environment

Everyone has the right to a healthy and safe environment that will ensure their physical and mental health or well-being, including adequate water supply, sanitation and waste disposal as well as protection from all forms of environmental danger, such as pollution, ecological degradation or infection.

Participation in decision-making

Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision-making on matters affecting one's health

Access to healthcare

Everyone has the right of access to health care services that include:

i. receiving timely emergency care at any health care facility that is open regardless of one's ability to pay;
ii. treatment and rehabilitation that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;
iii. provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, person living with HIV or AIDS patients;
iv. counselling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS;
v. palliative care that is affordable and effective in cases of incurable or terminal illness;
vi. a positive disposition displayed by health care providers that demonstrate courtesy, human dignity, patience, empathy and tolerance; and
vii. health information that includes the availability of health services and how best to use such services and such information shall be in the language understood by the patient.

Knowledge of one's health insurance/medical aid scheme

A member of a health insurance or medical aid scheme is entitled to information about that insurance or medical aid scheme and to challenge, where necessary, the decisions of such health insurance or medical aid scheme relating to the member.

Choice of health services

Everyone has the right to choose a particular health care provider for services or a particular health facility for treatment provided that such choice shall not be contrary to the ethical standards applicable to such health care providers or facilities, and the choice of facilities in line with prescribed service delivery guide lines.

Be treated by a named health care provider

Everyone has the right to know the person that is providing health care and therefore must be attended to by clearly identified health care providers

Confidentiality and privacy

Information concerning one's health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or an order of the court.

Informed consent

Everyone has the right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment and the costs involved, for one to make a decision that affects anyone of these elements.

Refusal of treatment

A person may refuse treatment and such refusal shall be verbal or in writing provided that such refusal does not endanger the health of others.

Be referred for a second opinion

Everyone has the right to be referred for a second opinion on request to a health provider of one's choice.

Continuity of care

No one shall be abandoned by a health care professional worker or a health facility which initially took responsibility for one's health.

Complain about health services

Everyone has the right to complain about health care services and to have such complaints investigated and to receive a full response on such investigation

Every patient or client has the following responsibilities:

- Advise the health care providers on his or her wishes with regard to his or her death.
- Comply with the prescribed treatment or rehabilitation procedures.
- Enquire about the related costs of treatment and/or rehabilitation and to arrange for payment.
- Take care of health records in his or her possession.
- Take care of his or her health.
- Care for and protect the environment.
- Respect the rights of other patients and health providers.
- Utilise the health care system properly and not abuse it.
- Know his or her local health services and what they offer.
- Provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counseling purposes

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Annexure 7: Checklist for element 7 - All service areas within the facility are clearly signposted

Use the checklist below to check whether all service areas within the facility are clearly signposted

Scoring – in column for score mark as follows:
Y (Yes) = if present; **N** (No) = if not present; **NA** (Not applicable) = signage is NA to the specific facility due to the services rendered or the size of the facility (small facilities) or type of services rendered

Internal branding	**Score**
Help Desk/Reception	
Complaints/suggestions/compliments box	
Medicine storage room/dispensary/pharmacy	
Chronic Medicine Collection (CCMDD)	
Emergency room	
Facility Manager – door identifier	
Emergency exit(s)	
Exit(s)	
Assembly points	
Stairs (if applicable)	
Patient Toilets	
Directional arrows to toilets	
Disabled toilet pictogram	
Female toilet pictogram	
Male toilet pictogram	
Directional signs for service areas - Colour-coded signage for each of the 3 streams of care service areas	
Acute/minor ailments (orange)	
Chronic Diseases (blue)	
MCWH (deep green)	
Health Support Services (Allied health services) (yellow)	
Medicine storage room/ dispensary/pharmacy	
Functional room signage (each area/room should be labelled)	
Vital signs	
Counselling room/s	
Consultation room/s	

Fire-fighting signs:	
At each hose, fire hose pictogram	
At each extinguisher, fire extinguisher pictogram	
Support/admin areas (room name sign on each door)	
Storeroom(s)	
Sluice room	
Laundry	
Cleaner's room	
Linen room	
Kitchen	
Patient records storage room	
Community Outreach Service	
Staff toilet(s)	
Staff room/boardroom/multipurpose room	
Total score	
Maximum possible score (sum of all scores minus those marked NA)	
Percentage (Total score ÷ Total maximum possible score) x 100	**%**

Note: Facilities with fewer than three consulting rooms are too small to be segregated into three streams and are not expected to have dedicated consulting areas for acute, chronic health conditions and preventative health services with accompanying signage. However, healthcare offered at these facilities should still adhere to ICSM principles. This means that patients should be treated holistically and not sent from one section to another because of co-morbidities. Signage for the three streams should therefore be marked as NA.

Annexure 8: Example of a dress code for staff

Dress code for staff

All staff members

- **An identification tag must be visibly displayed at chest level. The tag shall include the following information:**
  - emblem of the provincial Department of Health
  - initial/full names and surname of the staff member
  - staff designation e.g. "professional nurse", “data capturer”, “general assistant"
- **General appearance for all staff members**
  - clothing must be clean, neat and fit properly
  - shoes must be clean and in good condition
  - good personal hygiene principles must be adhered to at all times
  - the following is not allowed:
    - clogs, crocs, slip-ons
    - t-shirts
    - jeans, leggings, tights
    - see through clothes
    - low-cut necklines
    - hats
- **General appearance applicable for staff that provide direct patient care**
  - may not wear artificial nails or colored nail polish
  - nails must be short, clean and neatly trimmed
  - hair must be clean and long hair must be tied back
  - minimal jewelry must be worn
  - sleeves must be short (for infection control purposes)

Dress code for nursing staff

Prescribed uniform for females:	**Prescribed uniform for males:**
• white blouses (no see- through type) • navy jersey/jacket in the winter season • navy skirt/slacks • navy/black court/flat shoes - no clogs, crocs, slip-ons allowed • skin colour stockings • South African Nursing Council (SANC) approved distinguishing devises (epaulettes) must be worn at all times according to the nursing staff’s professional qualifications	• white collared shirts • navy jersey/jacket in the winter season • navy trousers • navy blue/black socks • black shoes – no clogs, crocs, slip-ons allowed • SANC approved distinguishing devises (epaulettes) must be worn at all times according to the nursing staff’s professional qualifications

Dress code for doctors

Prescribed uniform for females:	**Prescribed uniform for males:**
• neat blouses (no see- through type) • neat skirt/slacks • neat dress with appropriate length (not shorter than 10cm from above the knee) • jersey/jacket in the winter season	• neat collared shirts • neat trousers • jersey/jacket in the winter season • socks • closed shoes – no clogs, crocs, slip-ons

• court/flat shoes - no clogs, crocs, slip-ons • optional - white coat worn over clothes	• optional - white coat worn over clothes

Dress code for allied health workers

Allied groups	Dress colours
Occupational Therapist	green
Radiologist	brown
Speech Therapist	red
Physiotherapist	light blue
Dieticians and Nutritionist	navy

Prescribed uniform for females: • neat blouses (no see- through type) • skirt/slacks • neat dress with appropriate length (not shorter than 10cm from above the knee) • jersey/jacket in the winter season • court/flat shoes - no clogs, crocs, slip-ons	**Prescribed uniform for males:** • neat collared shirts • trousers • jersey/jacket in the winter season • socks • black shoes – no clogs, crocs, slip-ons

Dress code for administration staff, data capturers

- short or long sleeve shirt/blouse
- skirt/dresses of appropriate length, smart casual trousers
- cardigan, jersey or jacket in the winter season

Dress code for general assistants, community health workers and lay-councilors

- neat shirt or golf shirt (colours can be determined by district/province)
- neat trousers or skirts (colours can be determined by district/province)
- jersey or jacket in the winter season
- closed shoes and socks – no clogs, crocs, slip-ons allowed

Annexure 9: Checklist for element 9 - All staff members comply with prescribed dress code

Use the checklist below to check that staff on duty are dressed according to prescribed dress code

Scoring – in column for score mark as follows:

Check – randomly select five healthcare professional staff members to review

Y (Yes) = present and adhered to; **N** (No) = not present or not adhered to; **NA** (Not applicable) = if there are not enough staff on duty/appointed to evaluate five staff members, check those on duty, marking the remaining columns NA

Item	**Staff member 1**	**Staff member 2**	**Staff member 3**	**Staff member 4**	**Staff member 5**
Nails short					
Jewellery minimal (plain wedding band, small earrings, no necklaces)					
Dress/skirt OR pants (dress/skirt should not be shorter than knee length)					
Tailored clothes (not too tight nor too loose)					
Distinguishing devices worn					
Score					
Maximum possible score (sum of all scores minus those marked NA)					
Total score (sum of scores for 5 staff members)					
Total maximum possible score (sum of maximum possible minus those marked NA)					
Percentage (Total score ÷ Total maximum possible score) x100					

Annexure 10: Checklist for element 10 - All staff members wear an identification tags

Use the checklist below to check that the staff on duty wear official identification tags

Scoring – in column for score mark as follows:

Check – randomly select five staff members to review

Y (Yes) = present and adhered to; **N** (No) = not present or not adhered to; **NA** (Not applicable) = if there are not enough staff on duty/appointed to evaluate five staff members, check those on duty and mark remaining lines NA

Staff member	**Score**
Staff member 1	
Staff member 2	
Staff member 3	
Staff member 4	
Staff member 5	
Total score	
Total maximum possible score (sum of all scores minus those marked NA)	
Percentage (Total score ÷ Total maximum possible score) x 100	**%**

Note: Identification tag must include the emblem of the facility/district or provincial department of health, full names/initials and surname of the staff member

Annexure 11: Notice for prioritisation of very sick, frail and elderly patients

PLEASE NOTE

THE VERY SICK, FRAIL AND ELDERLY PATIENTS

WILL BE GIVEN PRIORITY

AND MOVED TO THE FRONT OF THE QUEUE

Annexure 12: Example of a Template for training register for staff

By signing against my name in the table below I acknowledge that I have undergone formal training on how to..... (insert details on specific training e.g. clean the facility)

STAFF NAME AND SURNAME	PERSAL NUMBER	DESIGNATION	SIGNATURE	DATE

Annexure 13: Checklist for element 12 - There is a process that prioritises the very sick, frail and elderly patients

Use the checklist below to check whether there is a process that prioritises the very sick, frail and elderly

Scoring - in column for score mark as follows:

Y (Yes) = compliant, **N** (No) = not compliant

Item	**Score**
The process to fast track very sick, frail and elderly users to the front of the queue is implemented. (The process to implement the fast-tracking of vulnerable users must be evident on observation of the waiting room. This should at a minimum include a poster or information provided to users about the process)	
SOP to prioritise the very sick, frail and elderly patients is available	
The SOP to prioritise the very sick, frail and elderly patients covers the following aspects:	
Prioritization procedure for the facility is described	
The procedure is displayed in at least two official languages in the waiting area indicating the prioritisation process	
In-service training of ALL staff on prioritisation process	
Delegate the function of prioritisation process to a designated staff member	
Conduct random spot checks during the day to determine whether the very sick, frail, and elderly patients are prioritised	
Total	
Score (Total ÷ 7)	

Annexure 14: Checklist for element 15 - Patient records adheres to ICSM prescripts

Use the checklist below to check whether patient records comply with ICSM prescripts

Scoring –in column for score mark as follows:

Check – randomly select five records of patients who were seen in the past three months. Include records for the following conditions: one adult acute/minor ailment, one adult chronic, one adult maternal health, one sick child and one well baby record to cover records of patients consulted at all three streams of care (Chronic, MCWH and Acute). Audit the last visit. Ensure that one of the five records selected is for a patient that was referred to another health facility (use the referral register to track such a file), this is to assess Element 204: Copy of referral letter available in the patient record.

Y (Yes) = recorded; **N** (No) = not recorded; **NA** (Not applicable) = if patient did not receive relevant treatment/measure does not apply to the particular type of record selected

Type of information/notes	**Adult acute/ minor ailment**	**Adult chronic**	**Adult maternal**	**Sick child (IMCI)**	**Well baby**
Administrative details (on cover of record)					
Clinic's name					
Name and surname					
Patient file number					
ID/Refugee/passport number OR date of birth					
Demographic details					
Residential address					
Personal contact details					
Name and surname of parents or guardian					
Contact details of parents or guardian					
Next of kin contact details					
Employment contact details (if employed)					
Marital status					
Gender					
Patient profile – 1st visit					
Type of employment					
Social (type of employment, living conditions, social assistance, cooking method)					
Social (school grade, social assistance, nutrition, where child resides)					
Health risk factors (alcohol, smoking, other substances, physical activity, healthy eating, sexual behaviour)					
Family history of chronic conditions					
Known chronic conditions					
Surgical history					
Allergies					
Clinical management					
Length/Height of patient at 1st visit					
Weight at every visit					
Body mass index (BMI) calculated at 1st and 7th visits					

Weight-for-height z score					
MUAC (every 3 months)					
Temperature					
Blood pressure at every visit					
Respiratory rate					
Pulse rate at every visit					
Blood sugar as per guidelines					
Urine dipstick as per guidelines					
Basic screening where indicated (HIV, TB, STI, Diabetes)					
Current chronic condition					
Adherence to medication					
Reported side effects of medication					
Other hospital/doctor visits					
Presenting complaints					
Examination					
General (JACCOL)					
Respiratory					
Cardiovascular					
Gastrointestinal					
Mental state					
Central nervous system (CNS)					
Musculo-skeletal					
Diagnosis					
Patient management					
Investigation/tests requested					
Date of investigation/test requested					
Results of investigations/test recorded					
Health education provided					
Treatment prescribed					
Rehabilitation (where applicable)					
Referral (where applicable)					
Date of next visit indicated (where applicable)					
Health Care Practitioner's name and surname					
Health Care Practitioner's qualification					
Health Care Practitioner's signature					
Date signed by Health Care Practitioner					
HPCSA Number (where applicable)					
Child health records					
History of immunisations					
Deworming treatment					
Vit A supplementation					
Developmental screening (6,14 weeks and 6, 9, 18 months and 3, 5-6 years)					
Growth charts completed					
Basic screening completed according to Road to Health Charts					
Maternal health records					
BANC 1st visit					
Obstetric history					
Previous obstetric history and family					
Gestational age					
General examinations					
Abdomen – FHH examination					
Vaginal examination					
HIV status					
Pregnancy risk screening					

Health education provided, including information on MomConnect					
Health Care Practitioner's name and surname					
Health Care Practitioner's qualification					
Health Care Practitioner's signature					
Date signed by Health Care Practitioner					
BANC PLUS follow-up visits					
HIV status (retest)					
General examination					
Abdomen examination					
Supplements (for the mother)					
Feeding practices for baby discussed					
Gestational graph plotted per visit					
Health Care Practitioner's name and surname					
Health Care Practitioner's qualification					
Health Care Practitioner's signature					
Date signed by Health Care Practitioner					
Delivery summary					
Birth date					
Birth weight					
Apgar score					
Delivery mode					
Pregnancy outcome					
Health Care Practitioner's name and surname					
Health Care Practitioner's qualification					
Health Care Practitioner's signature					
Date signed by Health Care Practitioner					
Postnatal Care visits					
General examination (3-6 days post delivery)					
General examination (6 weeks post delivery)					
Health education					
Health Care Practitioner's name and surname					
Health Care Practitioner's qualification					
Health Care Practitioner's signature					
Date signed by Health Care Practitioner					
Prescription					
Patient's name and surname					
ID number					
Age					
Allergies					
Name of medication					
Strength of medication					
Quantity					
Dosage					
Dosage form					
Batch number (applicable for immunizations)					
Prescriber's name and surname					
Prescriber's qualification					
Prescriber's signature					
Date signed by prescriber					
Dispenser's name and surname					
Dispenser's signature					
SANC/HPCSA number					
Consent form (where applicable)					
Patient's full names and surname are written on the consent form					

The user's age or date of birth or identity number is documented in the consent form					
The exact nature of the operation/procedure/treatment is written on the consent form					
The consent form is signed by the patient or parent/guardian					
The consent form is signed by the health care provider					
The consent form is dated					
The information is legible					
Total					
Total maximum possible score (sum of all scores minus those marked NA)					
Score (Total ÷ Total maximum possible score)					

Annexure 15: Checklist for element 16 - District/provincial SOP/guideline for filing, archiving and disposal of patient records is aligned to the national guideline

Use the checklist below to verify that the SOP/guideline describes the topics as listed

Scoring – in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant

Item	Score
Accessing of patient records	
Tracking of patient records	
Filing of patient records	
Storage of patient records	
Archiving of patient records	
Disposal of patient records	
Total	
Score (Total ÷ 6)	

Annexure 16: Checklist for element 17 - Guideline for filing, archiving and disposal of patient records is adhered to

Use the checklist below to determine whether the facility adheres to the SOP for filing, archiving and disposal of patient records

Scoring – in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant

Item	Score
Patient record storage room adheres to the following:	
Lockable with a security gate OR electronically controlled entrance (tag)	
There is a 'No unauthorized entry' sign on the door	
Shelves OR cabinets to store files	
Lowest shelf OR cabinets start at least 100 mm off the floor and the top of shelving is not less than 320 mm from the ceiling to allow airflow	
Aisle and shelves OR Cabinets labelled correctly according to SOP	
Counter or sorting table or dedicated shelves to sort files	
Light is functional and allows for all areas of the room to be well lit	
Room is clean and dust free	
Filing system for patient records adheres to the following:	
Facility retained patient records in use	
Standardised unique record registration number is assigned to files. One of the following methods is consistently used: patient's surname, identity document number or date of birth, or a set of facility-assigned and recorded numbers)	
Record registration number is clearly displayed on the cover of the patient record	
All patient records are filed as per SOP	
A tracking system is in place to check that all patient records issued for the day are returned to the patient records storage room/registry by the end of the day	
Annual register available of archived records	
Annual register available of disposed records	
Copy of disposal certificates available. Copies must correspond with entries in disposal register	
Access for patient to their records	
The SOP/guideline for filing, archiving and disposal of patient records describes the process to follow for patients to access their patient record	
Total score	
Percentage (Total score ÷ 18) x 100	**%**

Annexure 17: Checklist for element 23 - Priority stationery is available at the facility in sufficient quantities

Use the checklist below to check stationery availability

Scoring – in column for score mark as follows:

Y (Yes) = present; **N** (No) = not present; NA (not applicable) = if stationery is not applicable to the facility

Stationery type	**Facility minimum required quantity (Record must be available stipulating the facility's minimum required quantities)**	**Score**
Goods and supplies order forms/books		
Patient record for adults		
Patient record for children		
Road to Health Booklet for Boys and Girls		
Appointment Cards – General		
Patient information registers/Tick sheet		
WBPHCOT referral forms		
General referral forms		
Sick note		
Refusal of treatment forms		
Total score		
Maximum possible score (sum of all scores minus those marked NA)		
Percentage (Total score ÷ maximum possible score) x 100		**%**

ANNEXURE 18: Training register for staff trained on Integrated Clinical Service Management

By signing against my name in the table below I acknowledge that I have undergone formal training on indicated modules of ICSM.

Staff name and surname	Persal number	Desig-nation	Module 1	Module 2	Module 3	Module 4	Module 5	Module 6	Module 7	Module 8	Module 9	Module 10	Module 11	Module 12
			Signature and date	Signature and date	Signature and date	Signature and date	Signature and date	Signature and date	Signature and date	Signature and date	Signature and date	Signature and date	Signature and date	Signature and date

Annexure 19: Quality improvement plan

QUALITY IMPROVEMENT PLAN

Facility Name: _____

Date Generated: _____

Element #	Element	Weight	Respon-sibility	No	Partial	Comment	Activity	By Whom	When	Results
ADDITIONAL AREAS FOR IMPROVEMENT AS IDENTIFIED TRHOUGH SURVEYS, RISK ASSESSMENTS, COMPLAINTS										
Item							**Activity**	**By Whom**	**When**	**Results**

Name and Surname of facility manager: _____

Signature: _____

Date: _____

Annexure 20: CHECKLIST FOR ELEMENT 31: Quality Improvement plan address all areas, is signed and updated quarterly

Use the checklist below to check whether the facility's quality improvement plan address all areas, is signed and updated quarterly

Scoring - in column for score mark as follows:

Y (Yes) = Compliant, **N** (No) = no compliant, **NA** = if no gaps were identified in the specific area (verify whether there were no improvements needed by checking the results of the relating element)

Item	Score
Quality improvement plan is updated quarterly	
Quality improvement plan is signed by the facility manager	
Quality improvement plan address the following:	
Elements failed on the Ideal Clinic framework	
Gaps identified in the following areas are addressed:	
Patient experience of care surveys	
Complaints	
Patient safety incidents	
Clinical record audit	
Annual risk assessment for infection prevention and control	
Occupational health and safety register	
Security breaches	
Loss to follow-up of HIV and TB patients	
Tracer list medicine stock-out	
Laboratory specimen collection material stock-out	
Waiting Time	
Total	
Total maximum possible score (sum of all scores minus those marked NA)	
Score (Total ÷ Total maximum possible score)	

Annexure 21: Poster promoting adolescent and youth services

ADOLESCENT AND YOUTH SERVICES

Service times: 14h00 to 17h00

These are service times dedicated to adolescent and youth services. However, adolescents will be assisted throughout the day if a specific condition requires this.

Services will be provided in a friendly and supportive manner and include health promotion and disease prevention as well as curative interventions relating to sexual and reproductive health, HIV/AIDS and TB, mental health/illness, drug and substance abuse and violence and injury.

Annexure 22: Profile for adolescent and youth in the catchment area

Facility profile for adolescents and youth in the catchment area

Item	Percentage/Rate
Percentage youth (ages 10 to 24 years) in province (obtained from Stats SA's data)	
School dropout rate in the province (obtained from Stats SA's data)	
Percentage of youth who obtained tertiary qualifications in the province	
Percentage of youth unemployment in the province (obtained from Stats SA's data)	
Teenage pregnancies rate in the catchment area (obtained from DHIS)	
Description of strengths and challenges pertaining to youth in the catchment area using the above statistics	

Annexure 23: Checklist for element 44 - Adolescent and youth friendly health services are provided

Use the checklist below to check whether the facility renders services that are adolescent and youth friendly

Scoring – in column for score mark as follows:

Y (Yes) = if present and compliant; **N** (No) = if not present or not compliant

Item	**Score**
The National Adolescent and Youth Health Policy is available	
A poster indicating that the facility allocates dedicated time to consult adolescents and youth after school hours is visibly posted in the reception area and in consulting room(s) where AYFS are provided	
Facility's AYFS poster displays its comprehensive integrated package of AYFS services provided	
The facility's staff development plan makes provision for all healthcare professionals to be trained in AYFS	
The training register/record reflect that the healthcare professionals providing comprehensive integrated package of services to young people are trained on AYFS	
Facility's clinic committee includes a representative of the adolescent and youth sector aged 18-24 years	
Facility has a brief profile of adolescents and youth in its catchment area, including their challenges	
Total score	
Percentage (Total score ÷ 7) x 100	**%**

Annexure 24: Appointment scheduling process

1. PRE-APPOINTMENT RETRIEVAL OF CLINICAL RECORDS

Between 48 and 72 hours prior to the patient's appointment

- The designated appointment clerk, together with the administrative clerk at the front desk, should retrieve patients' records for each of the planned services.
- The clinical records then need to be provided for the relevant professional nurse who will be consulting planned patients for the various services.
- The relevant prescription and laboratory investigations should be updated where necessary.
- Clinical records should then be submitted to the pharmacy, or the nurse should pre-dispense the medication and store it appropriately.
- The patients' clinical records should then be stored at the registration point.

2. SCHEDULING OF PATIENT APPOINTMENTS

Once the starting date for consulting patients according to a scheduling system has been determined, the scheduling of patients should commence.

Who is responsible for scheduling the patients?

If only a single room is utilised to see patients with appointments for either chronic or MC&SRH, then the professional nurse could schedule the patient's next visit.

If more than one consultation room is used, then an appointment scheduling desk should be established near the exit of the facility, or patients should return to reception to schedule the next appointment.

How is the appointment date decided?

Depending on the patient's condition (immunisation, family planning, well-baby, post-natal care, ANC, and chronic care) and availability of medication at the facility, the patient will either return on a monthly basis, every 2nd or 3rd month or 6 monthly to the facility.

- The maximum number of patients to be consulted daily is pre-determined.
- At the beginning of each week, the professional nurses should determine and provide a 5- day period on which returning patients should be scheduled.
- This should be calculated between 25 and 30 days after the current date.
- The patient should then be given a choice as to the exact date when they would like to return within this period. The date should not be imposed on the patient.

Scheduling the appointment

Patients receiving an appointment will fall into various categories:

- Requiring a full clinical examination (6 month visit)
- Repeat visit (chronic, immunisation, family planning)
- Consultation by doctor
- Collection of medication – CCMDD facility based

The format chosen to schedule patients will be facility specific – a time format should be used as this spreads the workload.

In order to avoid the batching of patients and prolonging the waiting times, patients should be offered time slots for attending the appointment.

Patients requiring 6-month appointments should be distributed equally across the time slots or scheduled in a specific time slot to avoid prolonging the waiting times for other patients.

The time slots should be per 2-hour session with 10 patients scheduled per two-hour session (see example on the following page). At the end of each slot, two to three slots should be left blank for patients that missed scheduled appointments but returned within the 96-hour grace period.

Note: Frail, elderly and high-risk clients should be given priority.

Adolescents and youth should be scheduled after school hours.

Complete the consultation room number, day of the week and date.

Patients Details

Consultation Room: 5 Day of the week(circle) Date:

MON	TUES	WED
THUR	FRI	SAT

DD/MM/YYYY

No.	Record number	Full name and surname of patient	Comment	Record Retrieved		Appointment Attended		Record returned	
				Y	N	Y	N	Y	N
07.30-10.00									
1.	**2468013579**	**Mary Saints**	**CCMDD**	**Y**	N	Y	N	Y	**N**
2.					N	Y	N	Y	N
3.					N	Y	N	Y	N
4.					N	Y	N	Y	N
5.					N	Y	N		N
6.						Y			
7.					N	Y			
8.					N	Y			
9.					N	Y			
10.	**1234567890**	**James Doe**	**FU**	Y	N	Y			
10.15-12.45 (Tea time = 10.00-10.15)									
11.						Y	N		N
12.							N	Y	N
13.							N	Y	N
14.							N	Y	N
15.							N	Y	
16.	**2345678901**	**Polly Jacaranda**	**LR**				**N**	Y	**N**
17.							N	Y	N
18.							N	Y	N
19.							N	Y	N
20.							N	Y	N
13.30-16.00 (Lunch time= 12.45-1.30)									
21.				Y	N	Y			
22.				Y	N	Y			
23.				Y	N	Y			
24.				Y	N	Y			
25.				Y	N	Y	N		N
26.				Y	N	Y	N	Y	N
27.				Y	N	Y	N	Y	N
Missed appointments (*Record all patients who present with 5 working days of a missed appointment bellow.*)									
28.	**5678901234**	**Zenthembe Ndlovu**		**Y**	N	**Y**	N	Y	N
29.				Y	N	Y	N	Y	N
30.							N	Y	N
31.									N
32.									N

Complete Patient file number here. The unique patient record number generated by HPRS is 10 digits

Indicate if the patient's file was pre-retrieved. This should be done 48-72 hours before the scheduled

Indicate if the patient's record was returned to reception for

Indicate reason for appointment, e.g. laboratory results (LR), referred for doctor consultation (DR), collection of meds only (CCMDD), regular follow-up (6mth FU). This is done at the time that the

Complete patient's full name and

Indicate if the patient attended the

At the end of the day indicate how many patients attended their appointments, missed their appointments, records retrieved and records returned.

Total number of patients attended		Total number of missed appointments	
Total number of records retrieved		Total number of records returned	

PATIENT SCHEDULING TOOL

Date of appointment: This refers to a calendar date. You should label all the dates in the forms to cater for operating calendar days for the facility for the year. Eg 9th April 2012, 10th April 2012

No: Number refers to the numerical order in ascending order. This will guide you as to when you reach your target appointments for the respective date

Patient file number: This refers to the patient file number as on the patient record. This will facilitate easy retrieval of patient record prior to the appointment

Name and surname: This should be as reflected in patient's identity documents and or patient records

Diagnostic condition: This refers to the chronic condition for which the patient is booked. Eg: hypertension, diabetes, epilepsy, asthma, COPD, and ART

Investigations to be conducted or checked: Patients may require laboratory monitoring and investigations need to be conducted and checked. In this column record the investigations that need to be conducted on the following appointment or results that need to be checked.

Nature of appointment: In this column reflect the nature of patient appointment that will assist in triaging the patients as well as monitoring the patient in the process: e.g.

- Patient defaulted – referred for tracing. You can add address and health tracer's name
- Requiring a full clinical examination (6month visit)
- Repeat visit (chronic, immunisation, family planning)
- Consultation by doctor
- Collection of medication – CCMDD facility based

Attended: The last column should reflect if the patient attended (✓) of if the patient defaulted (x)

<u>What is the procedure when a patient misses their scheduled appointment date?</u>

The patient should be informed that should they miss their scheduled date:

Their record will be filed back in the main filing area after five working days

Should they come within five working days after their scheduled date, they will be consulted after all the patients allocated to that time slot have been consulted, even if they arrive first.

The patient will need to wait in the queues.

Should the patient arrive *after five working days*, they will need to follow the normal process of retrieving their files, wait for vital signs and be consulted in a vacant time slot.

How will an appointment system work in a single room and single nurse clinic?

- Chronic stable patients for medicines collection should be scheduled between 07h30 and 08h30 or between 15h00 and 16h00.
- Well-baby clinic, immunisation, post-natal visits and follow-up antenatal visits should be scheduled for the 1st 2 hours (8h30-10h30).
- Patients with acute episodic illness, antenatal first visits and patients for chronic prescription six month review should be scheduled between 10h30 and 14h00.
- Family planning and other preventive services should be offered between 14h30 and 16h00.
- Emergencies should be consulted at any time.

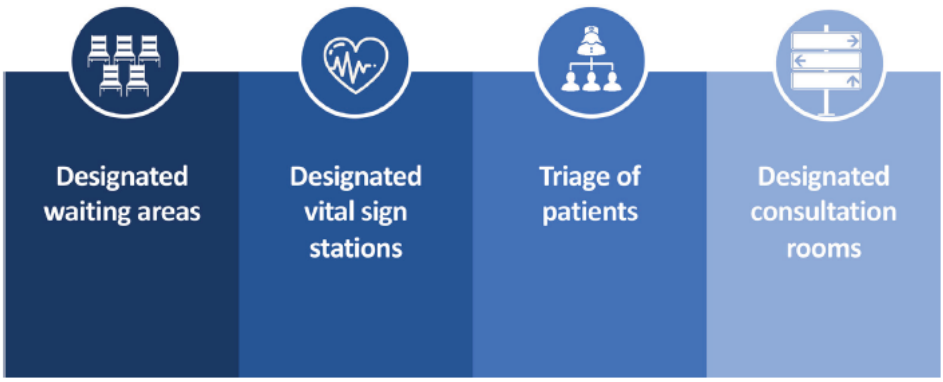
Ensure co-ordination of appointments, for example, a mother coming for a chronic appointment but also needing her baby to be immunised, should be given one appointment.

Patient defaulting on appointments

In order to improve the outcome of patients (chronic patients, ensure healthy mothers and babies, reduce unwanted pregnancies and prevent childhood infections) it is important that patients adhere to their appointment schedule.

Patients who miss appointments should be referred to the adherence counsellors to encourage and motivate them.

- A patient who does not return to the facility without informing the clinic within seven days of their scheduled appointment should be considered a defaulter.
- This patient's medication should be unpacked and re-distributed within the medication stock for supply to other patients.
- The patient's name, surname, physical address and mobile number should be retrieved from the patient's file and entered into the home based carers register with a comment- defaulter requiring follow-up.
- Home based carers should then visit the patient's home to discover the reasons for the default of the appointment and motivate the patient to return to the facility for further assessment.



Annexure 25: Pre-dispensing of chronic medication

- Two days prior to the patient's appointment, the patient's clinical records and scheduling list should be provided to the allocated professional nurse for chronic patients or the pharmacist's assistant, where available.
- The designated professional should pre-dispense (phase 1 and 2 of the dispensing process) the chronic medicine according to the prescription.
- The medicine should be packed in a brown bag or opaque plastic bag, where available.
- A sticker with the patient's name and file number should be placed on the external part of the bag.
- The bag should be sealed to avoid tampering. The bags can be opened when validation takes place upon issuing the medicine to the patient.
- Once the medicine has been pre-dispensed (phase 1 and 2), depending on the allocation of the patient, the medicine parcels should be placed in the medicine cupboard in alphabetical order, in the relevant consultation room, or kept in the dispensary if it is to be issued by a pharmacist's assistant.

Annexure 26: Example of a tool for acknowledging receipt of chronic medication by patient

TOOL FOR ACKNOWLEDGING RECEIPT OF CHRONIC MEDICATION BY PATIENT					
Name and surname					
Clinic file number					
Identity number or date of birth					
Month in schedule					
Date of medicine delivery					
Dispenser's signature (to be completed after checking, packing and labeling packet)					
Community health worker's signature upon receipt of medicine (sealed bag)					
Patient's signature on opening of sealed bag and checking medicine					
Medicine not delivered					

Annexure 27: School health service referral letter and follow-up assessment form

REFERRAL LETTER TO HEALTHCARE PROVIDER

Basic Education
Health

Date: _____

Dear colleague

Re: Referral for further assessment

During routine health screening it was found that _____

may have a problem with _____

_____

_____

_____and may require further assessment.

[Add findings in as much detail as possible from school health screening form e.g., Visual screening left eye 6/18 - Severe visual problem in the space provided above]

Kindly complete the attached follow up form indicating the outcomes of the assessment for attention of the school principal.

Yours sincerely

_____ _____

SIGNATURE (School Health Nurse) PRINT NAME

School Health Stamp

FOLLOW UP ASSESSMENT FORM

Basic Education
Health

Date: _____

Name of clinic: _____

Name of health provider: _____

Designation (e.g. Prof Nurse) _____

Contact number: _____

Dear Sir / Madam

FOLLOW UP OF HEALTH ASSESSMENT

The following learner _____was referred for further assessment as a result of the Integrated School Health Screening Programme.

Further assessment conducted ***Yes / No (tick whatever applicable).***

The child must return to the clinic for further treatment on _____ *(add date).*

Care and support at school level

The school can assist the child in the following ways:

[Add simple interventions e.g. sit at the front of the class for vision problems]

_____

_____

_____

_____

Please do not hesitate to contact the clinic/private healthcare provider should you require additional information at_____ (add contact numbers)

Yours sincerely

_____

NAME AND SIGNATURE OF HEALTH PROFESSIONAL

School Health Stamp

Annexure 28: Example of a register of learners referred from school health teams

REGISTER OF LEARNERS ASSESSED WHICH WERE REFREED BY SCHOOL HEALTH

Name of health facility: _____

Month and year: _____20_____

Name and surname of learner	Grade	Name of school	Reason for referral	Referral date	Date learner seen at facility	Date feedback provided to school health teams

Annexure 29: Referral and back referral form for WBPHCOT

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Referral Form (from outreach team to provider)

A person has been referred to your service by a member of the outreach team working in your ward. Community healthcare workers are mandated by the National Department of Health to identify community members in need of primary health and social services. Thank you for seeing this client, we look forward to working together for improved health and welfare for all South Africans.

Client referred to *(facility name)*	Date referral is made	Ward No

Name of CHW referring client	Outreach team leader name

Contact number for CHW											Team leader contact number										

Client details													
Client address											Client name and surname		
											Date of birth *(dd/mm/yyyy)*	Age	Gender
Client contact telephone number													

Referred to clinic *(Tick all that apply)*							
MCHW		**Under 5**		**Treatment related problems**		**Other**	
	Antenatal care		Newborn care		TM symptoms		Other health problems (specify below)
	Postnatal care		Low birth weight		STI testing		
	Pregnancy test		Immunisation		Mental health		
	Family planning		Vitamin A		Treatment adherence		
	Emergency contraception		Persistent diarrhoea		Chronic health problem		
	Cervical contraception		Pneumonia		Chronic health problem		
	PCR test for infants		Nutritional/growth problems		HCT		
					CD4 test		
					Ols		

Referred to social services (tick all that apply)				**Referred for home-based care (Please write condition that needs home care)**
	Child-headed household		Protection services	
	Food support		Grant support	
	Other (specify in box below)		Mental health	
			Support groups	
			Housing	
			Vital documents	

Provide a brief explanation for the referral *(Include place client is being referred if not above and reason for referral)*
Please complete Back-referral Form on the other side of this paper so we can ensure follow-up care. Please contact the outreach team leader noted on this form if you have any further questions regarding this referral.
Signed_____ Date_____

health Department: Health REPUBLIC OF SOUTH AFRICA	**Back-referral Form** **(from provider to outreach team)**
This client was seen by *(provider name)*	Date client seen *(dd/mm/yyyy)*
Facility name	Facility telephone number
Name of referring CHW	Name of team leader
Client details	
Client name and surname	Telephone number
Findings (include diagnosis with patient consent)	
Actions taken (including medicines given/prescribed if relevant)	
Follow-up actions to be monitored or completed by CHW	
Please send client back to this provider on/by_____ for further follow-up *(dd/mm/yyyy)*	
Signature	Date *(dd/mm/yyyy)*

Annexure 30: Checklist for element 50 - Facility refers environmental health related risks to environmental health services

Use the checklist below to check whether the facility has access to and refers environmental health risks to environmental health services

Scoring – in column for score mark as follows:

Y (Yes) = if available and compliant; **N** (No) = if not available or not compliant

Item	**Score**
Contact details of the environmental health services are available at the facility	
No stagnant water outside the perimeters of the facility	
No overgrown vegetation outside the perimeters of the facility	
No litter outside the perimeters of the facility	
Total score	
Percentage (Total score ÷ 4) x 100	**%**

Annexure 31: Check list for element 51 - The ICSM compliant package of clinical guidelines is available in all consulting rooms

Use the checklist below to check the availability of ICSM compliant package of clinical guidelines

Scoring – in column for score mark as follows:

Check – randomly select two consulting rooms

Y (Yes) = present; **N** (No) = not present; **NA** (not applicable) = at least one copy of EML for hospitals must be in doctor's room, therefore only one consulting room needs to have one; mark other consulting room as NA

Item	Score Consulting room 1	Score Consulting room 2
Adult Primary Care guide (APC) – 2019 or Practical Approach to Care Kit (PACK), 2019		
Integrated Management of Childhood Illness Chart Booklet, 2019		
Standard Treatment Guidelines and Essential Medicines List for Primary Health Care, 2020		
Standard Treatment Guidelines and Essential Medicines List for Hospital Level, Adults, 2019 **(only in consulting room used by the doctor)**		
Standard Treatment Guidelines and Essential Medicines List for Hospital Level, Paediatrics, 2017 **(only in consulting room used by the doctor)**		
Newborn Care Charts Management of Sick and Small Newborns in Hospital SSN Version 1,- 2014 **(only in consulting room used by the doctor)** (under review**)**		
Score		
Maximum possible score (sum of all scores minus those marked NA)		
Total score for all 2 consulting rooms		
Total maximum possible score (sum of all consulting rooms scores minus those marked NA)		
Percentage (Total score ÷ Total maximum possible score) x 100		**%**

* Guidelines can also be available electronically or via apps

Annexure 32: Check list for element 52 - National guidelines on priority health conditions are available in the facility

Use the checklist below to check the availability of national guidelines

Scoring – in column for score mark as follows:

Check – whether a copy of the guidelines and policies are available in an office that is accessible to staff

Y (Yes) = signed; **N** (No) = did not sign; **NA** (not applicable) = if the facility does not provide the service

Item	Score
Child, Youth and School Health	
South African Infant and Young Child feeding Policy (2013) (updated with circular in 2017)	
Non-Communicable diseases	
National User Guide on the Prevention and Treatment of Hypertension in Adults at PHC Level (2021)	
HIV	
Antiretroviral Treatment Clinical Guidelines for the Management of HIV in Adults, Pregnancy, Adolescents, Children, Infants and Neonates (2019)	
National HIV Testing Services Policy (2016)	
National Medical Male Circumcision Guidelines (2016)	
Standard Operating Procedures for Adherence Guidelines for HIV, TB and NCD (2020)	
National guidelines for the management of Viral Hepatitis (2019)	
TB	
National Tuberculosis Management Guidelines (2014)	
National Guidelines for the Management of Tuberculosis in Children (2013)	
Management of Rifampicin Resistance - A Clinical Reference Guide (2019)	
Women, Maternal and Reproductive Health	
Guidelines for Maternity Care in South Africa (2016)	
Cervical Cancer Prevention and Control Policy (2017)	
Clinical Guidelines for Breast Cancer Control and Management (2019)	
National Contraceptives clinical guidelines (2019)	
National Consolidated guidelines for the management of HIV in adults, adolescents, children and infants and prevention of mother-to-child transmission (2020)	
Maternal, Perinatal and Neonatal health policy (2021)	
Clinic Guideline for Genetics Services (2021)	
National Clinical Guidelines for Safe Conception and Infertility (2021)	
Total	
Total maximum possible score (sum of all scores minus those marked NA)	
Score (Total ÷ Total maximum possible score)	

***Guidelines can also be available electronically or via apps**

*** Check that the most current guidelines are used.**

Annexure 33: Checklist for element 56: SOP for informed consent is available

Use the checklist below to check whether the SOP covers the topics as listed

Scoring –in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant

Item	Score
Signatory providing consent must be legally entitled	
Exact nature of the procedure or treatment must be communicated to the patient	
Patient's full names must appear on the consent form	
Age/date of birth or identity number of patients must be reflected on the consent form	
Consent form must be signed by the health care provider who will perform the procedure	
The consent form must be dated	
All entries on the form must be legible	
Total	
Score ÷ 7	

Annexure 34: Example of a register for nurses trained on Basic Life Support

Record all the staff members' names and surnames in the register. Record the date the first training was conducted. Ensure that follow-up training is conducted every two years.

Keep a copy of the certificate obtained in a file together with the register

Staff name and surname	Persal number	Designation	Date of training	Date of update in 2 years	Date of update in 2 years	Date of update in 2 years
Nursing staff						

Annexure 35: Facility/district SOP for patient safety incident reporting and learning is available

Use the checklist below to check whether the SOP covers the aspects as listed

Scoring –in column for score mark as follows:

Y (Yes) = available; **N** (No) = not available

Item	Score
Terms of reference of the patient safety committee which reviews PSIs is clearly documented	
Designation of members of the committee	
Identifying patient safety incidents	
Immediate action	
Prioritisation	
Notification	
Investigation	
Classification	
Analysis	
Implementation of recommendations	
Learning	
Total	
Score ÷ 11	

Annexure 36: Patient Safety Incident reporting form

Section A: (notification) - to be completed by the staff who witnessed the incident that occurred. Submit section A and B to next level for notification for SAC 1 incidents.

Section B: (Account of the event by patient, staff or other witnesses) – to be completed by staff, patients or other that were directly involved while the incident took place.

Section C: (investigation) - to be completed by investigator(s) of the incident, in most cases this would be the manager(s) of section where the incident took place.

SECTION A – Notification of event

Ref no:

1. Date PSI identified				**2. Time PSI identified**							
3. Event identified by	Reported by health professional	Research studies	Patient experience of care surveys	Inpatient medical review	Review of record on follow-up	External sources			Safety walk rounds	Focused teams	Use of data
						Complaints	Media	Public			

4. Provide a short overview of the Patient Safety Incident
What happened/went wrong?
What is the initial outcome or harm?

5. Describe immediate actions taken to minimise harm
What action was taken to minimise harm?

Who led that action?
What was the outcome of the minimising action?

6. Provide a description of communication and escalation (initial disclosure)
What and how was the incident communicated with patient? (if appropriate)
What and how was the incident communicated with patient's family? (if appropriate)
What and how was the incident escalated to management within the facility? (if appropriate)

7. Type of patient safety incident (PSI): Mark with an X (review this once the investigation has been finalised)		
No harm	Near miss	Harmful (Adverse Event)

8. SAC rating: Mark with an X	**1 Serious**	**2 Moderate**	**3 Minor**	**4 None**	**9. Date SAC 1 reported to next level**		**11. No of days to report PSI with SAC = 1**	
					10. Time SAC 1 reported to next level			

12. Patient and ward information		**13. Staff witnesses**		
Patient name and surname		Name and surname	Contact detail	Department
Patient file number				
Patient Id number				
Location (department/ward)				

Age				
Gender				
Final diagnosis				
Number of patients in the ward/head count				
Name of facility patient was referred from (where applicable)				
Name of facility patient was down referred to (where applicable)		**14. Number of staff on duty**		
Compiled by:	**Designation:**	**Signature:**		**Date:**

SECTION B- Account of the event by patient, staff or other witnesses

1. Account by staff, patient or significant other: (Add sections for additional statements and information as needed)
Account 1:
Account 2:

Compiled by:	**Designation:**	**Signature:**	**Date:**

SECTION C – Investigation including classification

1. Classification according to incident type – mark appropriate one with an X			
1.Clinical administration	**3. Healthcare-associated infections**	**5. Blood and blood products**	**8. Patient accidents and self-inflicted injury**
Medical procedure performed without valid consent	Central line associated Blood Stream Infection	Acute transfusion reactions	Falls – Bedside
			Falls – Toilet/bathroom
Communication/ confidentiality	Non-device related (Primary) blood line blood infection	Delayed transfusion reactions/ events (including Transfusion Transmitted Infections)	Falls – Stretcher
			Falls – Therapeutic equipment
Patient incorrectly identified and recorded	Peripheral line blood infection	Errors- wrong blood/ blood products	Patient injury
Missing patient record	Surgical site infection	**6. Medical device/equipment**	Self-inflicted injury
Unclear/ ambiguous/ illegible/ incomplete information in patient record	Hospital acquired pneumonia	Not available	Suicide
	Ventilator associated pneumonia	Failure / malfunction	Attempted suicide
	Catheter associated urinary tract infection	Not used correctly	**9. Pressure ulcers acquired during/after admission**
	Communicable diseases		

2. Clinical process/ procedure	**4. Medication / IV fluids**	Incorrect medical device/ equipment used	Grade I
Not performed when indicated	Incorrect dispensing	**7. Behaviour**	Grade II
Performed on wrong patient	Omitted medicine or dose	Sexual assault by staff member	Grade III
Clinical procedure errors	Medicine not available	Sexual assault by fellow patient or visitor	Grade IV
Surgical procedure errors	Adverse drug reaction	Physical assault by staff member	**10. Infrastructure/ Buildings/ Fixtures**
Clinical treatment error (incorrect clinical management)	Incorrect medicine	Physical assault by fellow patient or visitor	Damaged/ faulty/ poor maintenance
	Incorrect dose/ strength administered		Non-existent
Clinical assessment error (Missed, delayed, wrong)	Incorrect patient	Exploitation, verbal abuse, aggression, neglect or degrading treatment by fellow patient or visitor	Inadequate/inappropriate
	Incorrect frequency		Back-up electricity not functional/available
	Incorrect route		Back-up water supply not available
Failure to act on test results or report	Prescription error	Exploitation, verbal abuse, aggression, neglect or degrading treatment by staff member	**1. Laboratory / Pathology**
Performed on wrong body part/ site/ side	Incorrect dispensing label		Delayed laboratory results
Retention of foreign object during surgery	Medicine expired	Patient abscond	Processing error by laboratory
	Incorrect technique	Missing patient Abscond while under 72-hour observation	Incorrect labelling of results
	Inappropriate polypharmacy		**12. Other**
			Any other incident that does not fit into categories 1 to 11

2. Framework for root cause analysis and implementation of action plans

a. Contributing factors – Mark with an X

1. Staff	Lack of knowledge of clinical processes/ guidelines/ protocols	Human error- clinical	Human error - Admin	Risky/reckless behaviour	Communication Factors	Condition/ disease related factor	Social factors	Leadership
2. Patient	Behaviour	Communication factor	Condition/ disease related factor	Social factors				
3. Work/ environment	Physical environmental / infrastructure	Remote/ long distance from service	Equipment (faulty due to no maintenance)	Consumables	Environmental risk	Current Code/ specifications/ regulations	Security/ safety	

4. Organisational/ service	Clinical Protocols/ policies/ procedures not available/ up to date/ approved	Non - Clinical Protocols/ policies/ procedures not available/ up to date/ approved	Organisational management/ decisions/culture	Organisation of teams	Staffing	Political unrest	Package of service	Bed utilisation
5. External	Natural event or disaster	Equipment, products malfunctioning due to manufacturer's fault	Services, systems and policies of external providers	Delays in emergency medical services transport				
6. Other	Not specified in classification 1 to 5							

b. Root cause analysis - These are the most fundamental underlying factors contributing to the incident that can be addressed

Contributing factor	Describe the factor that contributed to the event	Describe the action plan to rectify the identified problem	Person responsible for implementing the action plan	Date for implementation

3. Findings and recommendations of the investigation

What were the key findings (why did the incident occur)?

What are the key recommendations? (Note: Recommendations should address all the root causes and lessons learned, be designed to significantly reduce the likelihood of recurrence and/or severity of outcome; be clear and concise and kept to a minimum wherever possible; be Specific, Measurable, Achievable, Realistic and Timed (SMART) so that changes and improvements can be evaluated; be prioritised wherever possible; be categorised as: those **specific** to the area where the incident happened; those that are **common** only to; the organisation involved; those that are **universal** to all and, as such, have provincial/district significance.)

4. Type of behaviour according to Just Culture: mark with a X	**No error**	**Human error**	**At–risk behaviour**	**Reckless behaviour**

5. Provide a description of final communication to patient/family (final disclosure)

What and how was the incident communicated with patient? (if appropriate)

What and how was the incident communicated with patient's family? (if appropriate)									
6. Date of closure of PSI case		**7. No days to close PSI case**		**8. Type of closure: mark with an X**	**PSI case concluded**	**Litigation**	**Referred to labour relations**		
9. Patient outcome according to degree of harm: Mark with an X	No harm	Mild	Moderate	Severe	Neonatal trauma	Obstetric trauma	No longer classified as a PSI after investigation		
	Child death under 5 years	Child death 5 years and above	Adult death	Neonatal death	Maternal death	Still birth	Deaths due to hospital associated venous thromboembolism	Deaths due to health care associated sepsis	Perioperative death (30 days after surgery)
10. Organisational outcome: Mark with an X	Property damage	Increased length of stay	Admission to special care area (e.g., high care or ICU)	Additional treatment/tests	Additional staff required	Additional equipment required	Media attention		
	Formal complaint	Damaged reputation	Legal ramifications	None	Other	No longer classified as a PSI after investigation			
Compiled by:	Designation:	Signature:	Date:						

Annexure 37: Patient Safety Incident (PSI) register

HEALTH ESTABLISHMENT NAME: _____ MONTH/YEAR_____

Ref No.	Date and time of incident	Patient's name and surname	Age	Gender	Location (ward/ department/ area)	Type of PSI	SAC score	Reporting date of SAC 1 incidents	Number of working days to report SAC 1 incident	Summary of incident	Finding (all incidents) and recommendations by Patient Safety Committee	Class according to incident type	Class according to contributing factor	Patient outcome	Organisational outcome	Date PSI closed	Type of closure	# of working days to close PSI	Type of Behaviour

Annexure 38: Records for statistical data on Patient Safety Incident

Statistical data on classification for agents (contributing factor)

Establishment Name/Province:	**Financial Year:** Q=Quarter																		
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
	Apr	May	Jun	Q1	Jul	Aug	Sept	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	TOT	AVG	% *
1.Staff factors																			
Lack of knowledge of clinical processes/guidelines/protocols																			
Human error – clinical																			
Human error – administrative																			
Risky/reckless behaviour																			
Communication factors																			
Condition/disease related factors																			
Social factors																			
Leadership																			
2. Patient factors																			
Behaviour																			
Communication factors																			
Condition/disease related factors																			
Social factors																			
3. Work/environment factors																			
Physical environment/ infrastructure																			
Equipment																			
Consumables																			
Remote/long distance from service																			
Environmental risk																			
Security/safety																			
Current code/ specifications/regulations																			
4.Organisational/service factors																			
Clinical protocols/policies/ procedures																			
Non-clinical protocols/policies/ procedures																			
Organisational management/decisions/ culture																			
Organisation of teams																			
Staffing																			
Political unrest																			
Package of service																			
Bed utilisation																			
5. External factors																			
Natural event or disaster																			
Equipment/products malfunctioning due to manufacturer's fault																			
Services, systems and policies of external providers																			
Delays in emergency medical services transport																			

6. Other																			
Other																			
GRAND TOTAL																			

Total of contributing factors in Column Q ÷ Grand Total of Column Q

Statistical data on classification according to type of Incident

Establishment Name/Province:	Financial Year: *Q=Quarter																		
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
Type	Apr	May	Jun	Q1	Jul	Aug	Sept	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	TOT	AVG	% *
1.Clinical administration																			
Medical procedure performed without valid consent																			
Communication/confidentiality																			
Patient incorrectly identified and recorded																			
Missing patient record																			
Unclear/ambiguous/illegible/incomplete Information in patient record																			
2. Clinical process/procedure																			
Not performed when indicated																			
Performed on wrong patient																			
Clinical procedure errors																			
Surgical procedure errors																			
Clinical treatment error																			
Clinical assessment error																			
Failure to act on test results or reports																			
Performed on wrong body part/site/side																			
Retention of foreign object during surgery																			
3. Healthcare-associated infections																			
Central line associated blood stream infection																			
Non-device related (Primary) blood stream infection																			
Peripheral line blood stream infection																			
Surgical site infection																			
Hospital acquired pneumonia																			
Ventilator associated pneumonia																			
Catheter associated urinary tract infection																			
Communicable diseases																			
4. Medication/ IV fluids																			
Wrong dispensing																			
Omitted medicine or dose																			
Medicine not available																			
Adverse drug reaction																			
Wrong medicine																			
Wrong dose/strength administered																			
Wrong patient																			
Wrong frequency																			
Wrong route																			
Prescription error																			
Incorrect dispensing label																			

Medicine expired																			
Incorrect technique																			
Inappropriate polypharmacy																			
5. Blood or blood products																			
Acute transfusion reactions																			
Delayed transfusion reactions/ events																			
Errors- wrong blood/ blood products																			
6. Medical devises/equipment/ property																			
Not available																			
Failure/malfunction																			
Not used correctly																			
Incorrect medical device/equipment used																			
Not available																			
Failure/malfunction																			
7. Behaviour																			
Sexual assault by staff member																			
Sexual assault by fellow patient or visitor																			
Physical assault by staff member																			
Physical assault by fellow patient or visitor																			
Exploitation, verbal abuse, aggression, neglect or degrading treatment by fellow patient or visitor																			
Exploitation, verbal abuse, aggression, neglect or degrading treatment by staff member																			
Missing patient																			
Patient abscond																			
Abscond while under 72-hour admission																			
8. Patient accidents and self-inflicted injury																			
Falls – Bedside																			
Falls – Toilet/bathroom																			
Falls – Stretcher																			
Falls – Therapeutic equipment																			
Falls – Other																			
Patient injury																			
Self-inflicted injury/self-harm																			
Suicide																			
Attempted suicide																			
9. Pressure ulcers acquired during/after admissions																			
Grade I																			
Grade II																			
Grade III																			
Grade IV																			
10. Infrastructure/ buildings/ fixtures																			
Damaged/faulty/worn																			
Non-existent																			

Inadequate/inappropriate																			
Back-up electricity not functional/available																			
Back-up water supply not available																			
11. Laboratory / Pathology																			
Delayed laboratory results																			
Processing error by laboratory																			
Incorrect labelling of results																			
12. Other																			
Any other incident that does not fit into category 1 to 11																			
GRAND TOTAL																			

** Total of type in Column Q ÷ Grand Total of Column Q*

Statistical data on classification according to incident outcome

PATIENT OUTCOME																			
Establishment Name/Province:	**Financial Year:** Q=Quarter																		
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
	Apr	May	Jun	Q1	Jul	Aug	Sept	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	TOT	AVG	%*
No harm																			
Mild																			
Moderate																			
Severe																			
Child death under 5 years																			
Child death 5 years and above																			
Adult death																			
Neonatal death																			
Maternal death																			
Still birth																			
Deaths due to hospital associated venous thromboembolism (up to 90 days post discharge)																			
Deaths due to healthcare associated sepsis																			
Perioperative death																			
Neonatal trauma																			
Obstetric trauma																			
No longer classified as a PSI after investigation																			
GRAND TOTAL																			

ORGANISATIONAL OUTCOME																				
Establishment Name/Province:	**Financial Year:** Q=Quarter																			
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	
	Apr	May	Jun	Q1	Jul	Aug	Sept	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	TOT	AVG	%*	
Property damage																				
Increased length of stay																				
Admission to special care area (e.g. high care or ICU)																				
Additional treatment/tests																				
Additional staff required																				
Additional equipment required																				
Media attention																				
Formal complaint																				
Damaged reputation																				
Legal ramifications																				
None																				
No longer classified as a PSI after investigation																				
Other																				
GRAND TOTAL																				

** Total of outcome in Column Q ÷ Grand Total of Column Q*

Statistical data on indicators for patient safety Incidents

Name of establishment/province: _____

Financial Year: _____

Column Name	A	B	C	D	E	F	G	H
Month:	# PSI cases	#PSI cases closed	% PSI cases closed (Column B/ Column A)	# PSI cases closed within 60 working days	% of PSI cases closed within 60 working days (Column D/ Column B)	# PSI SAC 1	# SAC 1 incidents reported within 24 hours	%of SAC 1 incidents reported within 24 hours (Column F/ Column G)
April								
May								
June								
Quarter 1								
July								
Aug								
Sept								
Quarter 2								
Oct								
Nov								
Dec								
Quarter 3								
Jan								
Feb								
March								
Quarter 4								
TOTAL								
AVG								

Annexure 39: Checklist for element 61 - Patient safety incident management records show compliance to the national guideline for patient safety incident reporting and learning

Use the checklist below to check the availability of records required for the effective management of /Patient Safety Incidents

Scoring –in column for score mark as follows:

Check –patient safety records for the past three months.

Note:

- In cases where no incidents occurred in the past three months. The *Patient Safety Incident Compliance* report for the facility as generated from the national web-based information system must show 100% compliance for "Null" reporting for the facility for the past 3 months, facility then score 'NA' for the measures as listed

Y (Yes) = available; **N** (No) = not available; NA (Not Applicable) = if facility did not record patient safety incidents in the past three months

Item	Score
Patient Safety Incident Register	
Completed Patient safety incident form with investigation report is available for all patient safety incident cases that have been closed	
Statistical report for classifications of agents involved	
Statistical report for classifications of incident type	
Statistical report for classifications of incident outcome	
Statistical report for Indicators for patient safety incidents	
Total	
Total maximum possible score (sum of all scores minus those	
Score (Total ÷ Total maximum possible score)	

Annexure 40: Checklist for element 64 - Clinical audits are conducted annually on priority health conditions

Use the checklist below to check whether clinical audits are conducted for all the priority health conditions annually

Scoring - In column for score mark as follows:

Y (Yes) = audit conducted, **N** (No) = audit not conducted. **NA** (Not applicable) = if the facility does not provide treatment for the specific health condition.

If the condition has not been audited in the current financial year as the next due date for audit is still to come; assess the previous financial year's records for that condition.

Item	Score
HIV/TB	
NCD (diabetes and hypertension)	
Maternal health (ANC &PNC)	
Well baby	
Sick child (IMCI)	
Total	
Score (Total ÷ 5)	

Annexure 41: Checklist for element 65: 80% of records audited are compliant

Use the checklist below to check whether 80% of the records that were audited for the priority health conditions are compliant according to defined measures

Scoring - In column for score mark as follows:

Y (Yes) = scored 80% or more, **N** (No) = scored less than 80%. **NA** (Not applicable) = if the facility does not provide treatment for the specific health condition.

Audit the current financial year records, if the condition has not been audited in the current financial year as the next due date for audit is still to come; assess the previous financial year's records for that condition.

Item	Score
HIV/TB	
NCD (diabetes and hypertension)	
Maternal health (ANC &PNC)	
Well baby	
Sick child (IMCI)	
Total score	
Percentage (Total score ÷ 5) x 100	**%**

Annexure 42: Notifiable Medical Conditions

Notifiable medical conditions (NMC) to be reported by health facilities are those diseases that are important to public health because they pose significant risks that can result in disease outbreaks or epidemics with high facility rates nationally and internationally. Notification of certain medical conditions in South Africa is based on the Health Act, 1977 (Act No. 63 of 1977: Regulation 1434: Regulation relating to the surveillance of the control of notifiable medical conditions. Regulations on Notifiable Medical Conditions prescribe the diseases in South Africa that need to be notified by every health care provider and how soon after clinical diagnosis this information is required for each condition to break the cycle of transmission. This section provides a summary of the reporting system.

a. Why notify?

- International Health Regulations (IHR) and the South African National Health Act require rapid detection, notification and prompt risk assessment of public health risks to enable timely and targeted public health response.
- Notifications serve as early warning signs for possible outbreaks hence enable efficient public health actions to contain or prevent such outbreaks.
- Notifications provide empirical data required to monitor disease distribution and trends and identify populations at risk, and for policy decisions.

b. Who should notify a Notifiable Medical Condition (NMC)?

Every doctor or nurse (health care provider) who diagnoses a patient with any one of the NMC.

c. Where to obtain information on how to report NMC?

The National Standard Operating Procedure *with flow chart, case definitions and case investigation forms are available from www.health.gov.za. The NMC Notification booklet from the NMC focal person at the province/district.*

d. What and when to report NMC?

NMCs are categorised into four categories, i.e. category 1, 2, **3 and 4**. See **Table 41.**

NMCs reported by health facilities:

Category 1 NMC are conditions that require **immediate reporting by the most rapid means available** upon clinical or laboratory diagnosis followed by a written or electronic notification to the Department of Health within 24 hours of diagnosis by health care providers.

Category 2 NMC are conditions that must be **notified through a written or an electronic notification** to the Department of Health within 7 days of diagnosis.

NMCs Reported by private and public laboratories:

Category 3 and 4.

Categories of NMCs

Category 1 NMC	Category 2 NMC
Acute flaccid paralysis	Agricultural or stock remedy poisoning
Acute rheumatic fever	Bilharzia (schistosomiasis)
Anthrax	Brucellosis
Botulism	Congenital rubella syndrome
Cholera	Congenital syphilis
Food borne illness outbreak	Diphtheria
Enteric fever (typhoid or paratyphoid fever)	Enteric fever (typhoid or paratyphoid fever)
Malaria	*Haemophilus influenzae* type B
Haemolytic uraemic syndrome	Hepatitis A
Listeriosis	Hepatitis B
Measles	Hepatitis C
Meningococcal disease	Hepatitis E
Pertussis	Lead poisoning
Plague	Legionellosis
Poliomyelitis	Leprosy
Rabies (human)	Maternal death (pregnancy, childbirth and puerperium)
Respiratory disease caused by a nove respiratory pathogen	Mercury poisoning
Rift valley fever (human)	Pertussis
Smallpox	Soil-transmitted helminth infections
Viral haemorrhagic fever diseases	Tetanus
Waterborne illness outbreak	Tuberculosis: pulmonary
Yellow fever	Tuberculosis: extra-pulmonary
	Tuberculosis: multidrug-resistant (MDR-TB)
	Tuberculosis: extensively drug-resistant (XDR-TB)
Category 3 NMC	**Category 4 NMC**
Ceftriaxone-resistant Neisseria gonorrhea	Carbapenemase-producing Enterobacteriaceae
West Nile virus, Sindbis virus, Chikungunya virus	Vancomycin-resistant enterococci
Dengue fever virus other imported arboviruses of medical importance	Staphylococcus aureus: hGISA and GISA
Salmonella spp. other than S. typhi and S. paratyphi	Colistin-resistant Pseudomonas aeruginosa
Rubella virus	Colistin-resistant Acinetobacter baumanii
Shiga toxin-producing Escherichia coli	Clostridiode difficile
Shigella spp	

a. How to report NMC?

Reporting can be done either via a paper based or an electronic notification.

Paper based notification

- Complete the NMC Case Notification Form which may be found on the NICD website.
- Send the NMC Case Notification Form to NMCsurveillanceReport@nicd.ac.za or fax to 086 639 1638 or send a photograph by sms, Whatsapp, email or fax to the NMC hotline 072 621 3805. .
- Send a copy to the NMC focal person at Sub-District/District (details given on the NMC Notification booklet cover page).
- The NMC Focal Person at health facility level or Sub-District must ensure that the forms are captured electronically.

OR

Electronic notification via the NMC APP

- On the NICD webpage (www.nicd.ac.za) find the Notifiable Medical Conditions page. Follow the instructions to download the application (APP) onto your smartphone or open the APP on your laptop or PC.
- Follow the registration process. You will need to provide a HPCSA registration number (medical practitioner) or a SANC registration number (professional nurse).
- Capture the NMC case details onto the NMC APP using the patient's file and laboratory results (if available).
- The notification will automatically be sent via the APP to all relevant focal persons at facilities, Sub-District, District, Province & National levels. Category 1 conditions will be notified to focal persons by SMS to ensure immediate response.

Annexure 43: Checklist for element 67 - National guidelines are followed for all notifiable medical conditions

Use the checklist below to determine whether the National guidelines are followed for all notifiable medical conditions

Scoring – in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant

Item	Score
Notifiable Medical Conditions booklet available or have access to the web-based application to report Notifiable Medical Conditions	
All notifiable diseases are reported using the prescribed form or the web-based application	
Proof of submission of completed forms available	
Total	
Score (Total ÷ 3)	

Annexure 44: Checklist for element 68 - SOP for the management of patients with highly infectious diseases is available

Use the checklist below to check whether the topics as listed are described in the SOP

Scoring – in column for score mark as follows:

Y (Yes) = present; **N** (No) = not present

Item	Score
Room identified or dedicated area to isolate patients with suspected highly infectious disease.	
Procedure for terminal cleaning of the identified room to isolate patients with suspected highly infectious disease is detailed	
Personal Protective equipment required for treatment of infectious patients and cleaning of the room is listed	
Total	
Score (Total ÷ 3)	

Annexure 45: Checklist for element 71: SOP for standard precautions is available

Use the checklist below to check whether the content of the SOP describes the items as listed

Scoring – in column for score mark as follows:

Y (Yes) = present; **N** (No) = not present

Item	**Score**
Hand hygiene	
Personal Protective Equipment	
Patient placement	
Appropriate use of antiseptics, disinfectant and detergents	
Respiratory hygiene and cough etiquette	
Injection safety, prevention of injuries from sharp instruments, post-exposure prophylaxis, medical surveillance and medical surveillance	
Environmental cleanliness	
Health care waste management	
Decontamination of medical devices	
Handling of linen and laundry	
Principles of asepsis	
Total	
Score (Total ÷ 11)	

Annexure 46: Checklist for element 72 - All staff have received in-service training in the last two years on standard precautions that is in-line with the SOP

Use the checklist below to check whether staff has received in-service training on infection prevention and control in the past 2 years

Scoring – in column for score mark as follows:

Check – randomly select two health care professional and two cleaners from the facility's staff establishment. If the facility has less than four staff members on their staff establishment, check all the staff

Y (Yes) = staff member was trained; **N** (No) = staff member was not trained; **NA** (Not applicable) = if there are fewer than 4 staff members

Topics included in training	Healthcare Professional 1	Healthcare Professional 2	Cleaner 1	Cleaner 2
Healthcare professionals received training on:				
Hand hygiene				
Personal Protective Equipment				
Patient placement				
Appropriate use of antiseptics, disinfectant and				
Respiratory hygiene and cough etiquette				
Injection safety, prevention of injuries from sharp				
Environmental cleanliness				
Health care waste management				
Decontamination of medical devices				
Handling of linen and laundry				
Principles of asepsis				
Cleaners received training on:				
Hand hygiene				
Handling of linen and laundry				
Personal Protective Equipment				
Respiratory hygiene and cough etiquette				
Environmental cleanliness				
Health care waste management				
Total				
Total maximum possible score (sum of all scores minus those marked NA)				
Score (Total ÷ Total maximum possible score)				

Annexure 47: Poster – Hand wash technique

July 2020

How to wash your hands

- Wash visibly soiled hands with soap and water, otherwise use alcohol-based hand rub.
- Keep nails short and clean. Avoid artificial nails as they do not allow for adequate cleaning/disinfection.

Wash your hands for 40-60 seconds using steps below:

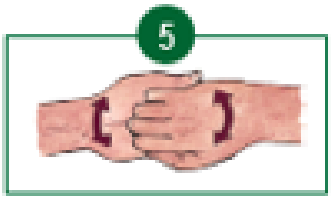
40-60 seconds

Wet hands in clean water and apply soap to palm.

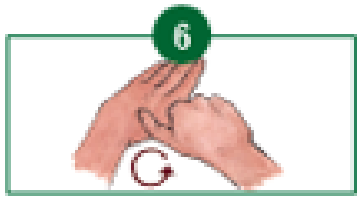
Rub palms together.

Place one hand over back of other, rub between fingers. Swap hands.

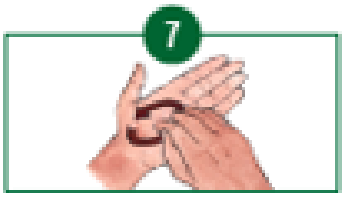
Rub fingers between each other.



Grip fingers and rub together.

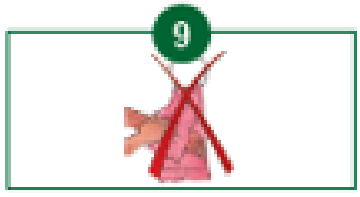


Rub each thumb with opposite palm. Swap hands.



Rub tips of nails against palm. Swap hands.

Rinse hands with water.



- Avoid shared towels.
- Dry using paper towel.
- Use paper towel to turn off tap.

Once dry, your hands are safe.

health

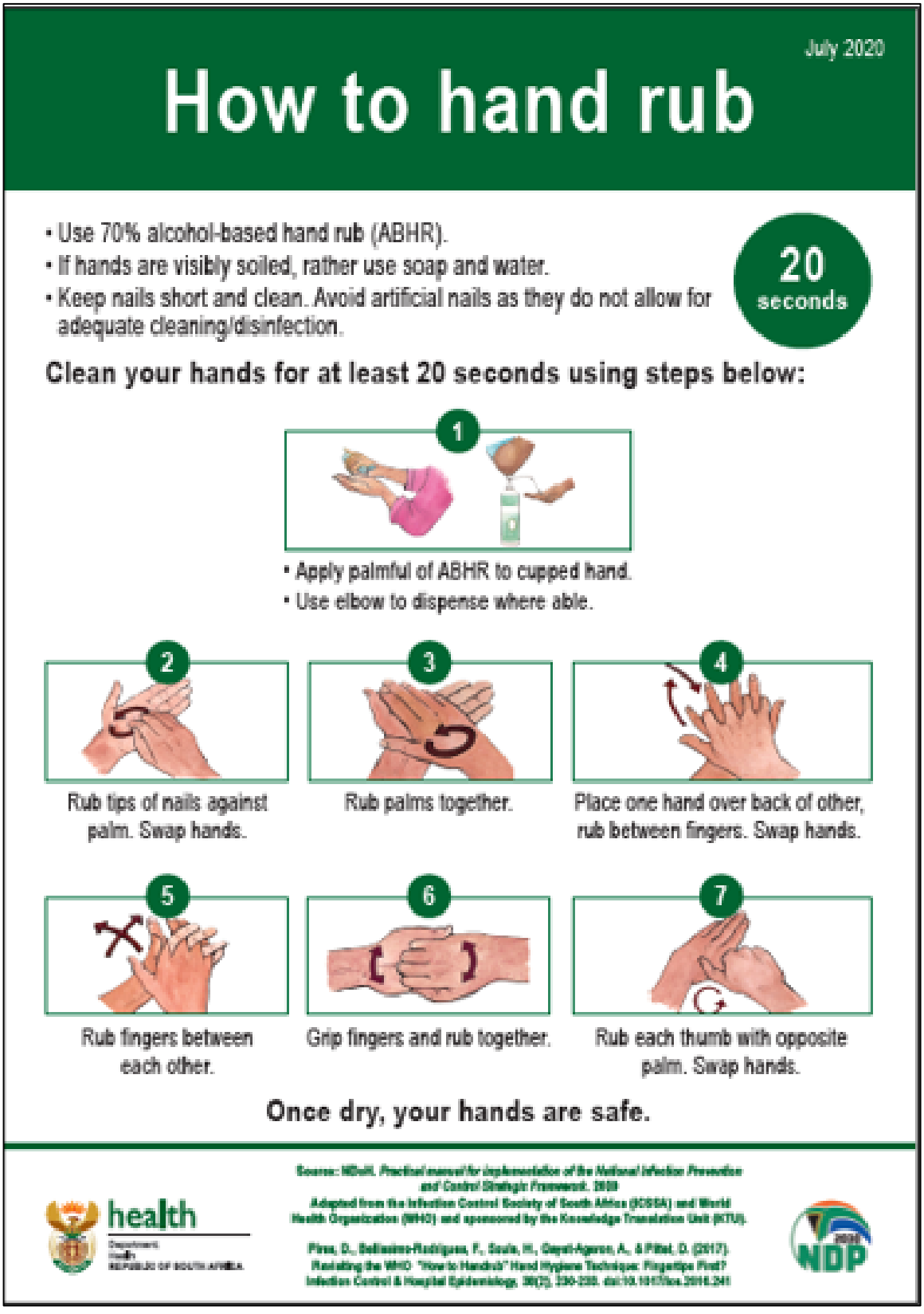
Source: NDoH. Practical manual for implementation of the National Infection Prevention and Control Strategic Framework. 2020

Adapted from the Infection Control Society of South Africa (ICSSA) and World Health Organization (WHO) and sponsored by the Knowledge Translation Unit (KTU).

Pires, D., Bellissimo-Rodrigues, F., Soule, H., Gayet-Ageron, A., & Pittet, D. (2017). Revisiting the WHO "How to Handrub" Hand Hygiene Technique: Fingertips First? Infection Control & Hospital Epidemiology, 38(5), 559-562. doi:10.1017/ice.2016.341

NDP

Annexure 48: Poster – Alcohol-based hand rub technique



Annexure 49:: Checklist for element 73 - Posters on hand hygiene is displayed

Use the checklist below to check whether posters on hand hygiene is displayed

Scoring –in column for score mark as follows:

Check – randomly select the areas as indicated and check whether the posters are available

Y (Yes) = compliant; **N** (No) = not compliant; **NA** (not applicable) = if the facility has fewer areas than indicated.

Item	Score Viral area	Score Consulting room	Score Toilet
Poster for hand hygiene technique displayed near hand wash basin			
Poster for alcohol-based hand rub technique displayed on the notice board (or wall where there is no notice board)			
Total			
Total maximum possible score (sum of all scores minus those marked NA)			
Score (Total ÷ Total maximum possible score)			

Annexure 50: Poster – Cough Etiquette

July 2020

Cover your cough and sneeze

DON'T

Don't cough or sneeze without covering your mouth and nose.

DO

Cover your mouth and nose with a tissue and throw it away immediately after use.

Cough or sneeze into your upper sleeve.

Cough or sneeze inside your shirt or top.

Wash your hands with soap and water immediately after coughing or sneezing.

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Source: NDoH. *Practical manual for implementation of the National Infection Prevention and Control Strategic Framework. 2020*
Adopted from and sponsored by the Knowledge Translation Unit (KTU).

2030 NDP

Annexure 51: Checklist element 76 - Staff wear appropriate personal protective clothing

Use the checklist below to check whether protective clothing is available and worn

Scoring – in column for score mark as follows:

Y (Yes) = available and worn; **N** (No) = not available or not worn; **NA** (not applicable) = if staff is not in a situation where they need to wear protective clothing at the time of the audit

Item	Score -stock available	Score - worn by staff
Gloves – non sterile		
Gloves – sterile		
Disposable gowns OR aprons		
Protective face shields OR goggles		
Surgical face masks		
N95 Respirators		
Score		
Maximum possible score (sum of all scores minus the ones marked NA)		
Total score for all stock available and worn by staff		
Total maximum possible score (sum of stock available and clothing worn by staff minus those marked NA)		
Percentage (Total score ÷ maximum possible score) x 100		**%**

Annexure 52: Checklist for Element 77: The linen in use is sufficient, clean, appropriately used and not torn

Use the checklist below to check whether the linen is clean, appropriately used and not torn

Scoring - In column for score mark as follows:

Y (Yes) = compliant, **N** (No) = not compliant. NA = Where the type of linen listed (cloth/disposable) is not used.

Item	Score
All examination couches are covered with linen	
Cloth linen (i.e. couch cover, two draw sheets, two sheets, two pillowcases) is available for each consultation room	
Disposable linen – at least 30 draw sheets per consultation room	
Linen is clean	
Linen is appropriately used for its intended purpose	
Linen is not torn	
Total	
Total maximum possible score (sum of all scores minus those marked NA)	
Score (Total ÷ Total maximum possible score)	

Annexure 53: Poster for waste segregation and colour coding

Colour coding and labelling of health care waste

Waste category	Waste sub category	Colour coding	Labelling	Examples of waste
Infectious anatomical waste	None	**RED**	Have the international infectious hazard label Marked “infectious waste”	Tissues, organs, body parts or products of conception from surgeries and autopsies
Infectious waste	None	**RED**	Have the international infectious hazard Label Marked “infectious hazard”	All microbiology laboratory wastes, waste from surgeries and autopsies and all contaminated waste produced during treatment of patients
Sharps	None	**YELLOW**	Have the international infectious hazard Marked “Danger contaminated sharps”	Items that could cause cuts or puncture wounds; needles, hypodermic needles, scalpels and other blades, knives, infusion sets, saws, broken glass and pipettes
General waste	None	**BLACK** BEIGE WHITE TRANS-PARENT	Marked general waste **Note:** Provinces/organisation should choose one colour and use only that colour throughout the province/organisation. **Transparent bags are recommended to be able to identify content**	Domestic waste, building and demolition waste, business waste (waste that does not pose an immediate hazard or threat to health or to the environment)
Chemical waste including pharmaceutical waste	Chemical or pharmaceutical	**DARK GREEN**	Have the international hazard label Marked “pharmaceutical waste-liquid or Pharmaceutical waste-solid” AND for flammable liquids or solids marked “Highly flammable” or “Flammable”	**Pharmaceutical:** unused medicines, medications and residues of medicines that are no longer usable as medication **Chemical**: Solid, liquid and gaseous products that are to be discarded and that contain dangerous or polluting chemicals that pose a threat to humans, animals or the environment, when improperly disposed off
	Cytotoxic or genotoxic pharmaceutical	**DARK GREEN**	Have the international Cytotoxic hazard label Marked “Cytotoxic waste” or “Genotoxic waste” OR Marked “Cytotoxic sharps” or “ Genotoxic Sharps”	Certain expired drugs, vomit, urine, or faeces from patients treated with cytostatic drugs, genotoxin or cytotoxin contaminated sharps or pharmaceuticals
Radioactive waste	None	NO COLOUR CODING	Have the international radiation hazard label Name and contact number of the radiation officer, for emergency purposes	Liquid, solid or gaseous materials that contain or are contaminated with, radio nuclides.

Annexure 54: Checklist for element 79: Sharps are disposed of appropriately

Use the checklist below to check whether sharps are disposed of appropriately

Check - randomly check two consulting rooms

Scoring - In column for score mark as follows:

Y (Yes) = compliant, **N** (No) = not compliant; **NA** (not applicable) = if the facility only has one consulting room

Item	Score Consulting room 1	Score Consulting room 2
Health care risk waste is properly segregated		
Sharps are disposed of in impenetrable, tamperproof containers		
Sharps containers are disposed of when they reach the limit mark		
Sharps containers are placed on work surface or in wall mounted brackets		
Used needles are not recapped before disposal		
Total		
Total maximum possible score (sum of all scores minus those marked NA)		
Score (Total ÷ Total maximum possible score)		

Annexure 55: Checklist for element 81 – All staff are made aware of the letter/memo/circular that informs staff of the procedure to follow for prophylactic immunisations

Use the checklist below to check whether staff are made aware of the SOP on access to prophylactic immunisations for high risk infections

Scoring - In column for score mark as follows:

Y (Yes) = compliant, **N** (No) = not compliant.

Item	Score
Staff signed acknowledgment of the letter/memo/circular that sets out the guidelines for prophylactic immunisations	
Letter/memo/circular from the provincial head of health or the delegated staff member at the provincial office contains the following information:	
Procedure to follow for prophylactic immunisations	
Who will bear the cost of immunizations	
Recommended vaccinations as determined by the disease profile of the health facility or region	
Total	
Score (Total ÷ 4)	

Annexure 56: Checklist for element 88 - Results of the annual patient experience of care survey are visibly displayed at the main waiting area

Use the checklist below to check whether the results of the patient experience of care survey are displayed at the main waiting area

Scoring - In column for score mark as follows:

Y (Yes) = compliant, **N** (No) = not compliant.

Item	Score
Access to services - Level of user experience with accessibility of health care services	
Availability and use of medicines - Level of user experience with availability and use of medicines	
User safety - Level of user experience with physical safety while in the health establishment	
Cleanliness and infection prevention and control - Level of user experience with cleanliness of a health establishment and infection prevention and control practices in the health establishment	
Values and attitudes - Level of user experience of personnel values and attitudes	
User waiting time - Level of user experience with waiting time for services in the health establishment	
Total	
Score (Total ÷ 6)	

Annexure 57: Template for commitment of the facility to improve/sustain the results of the patient experience of care

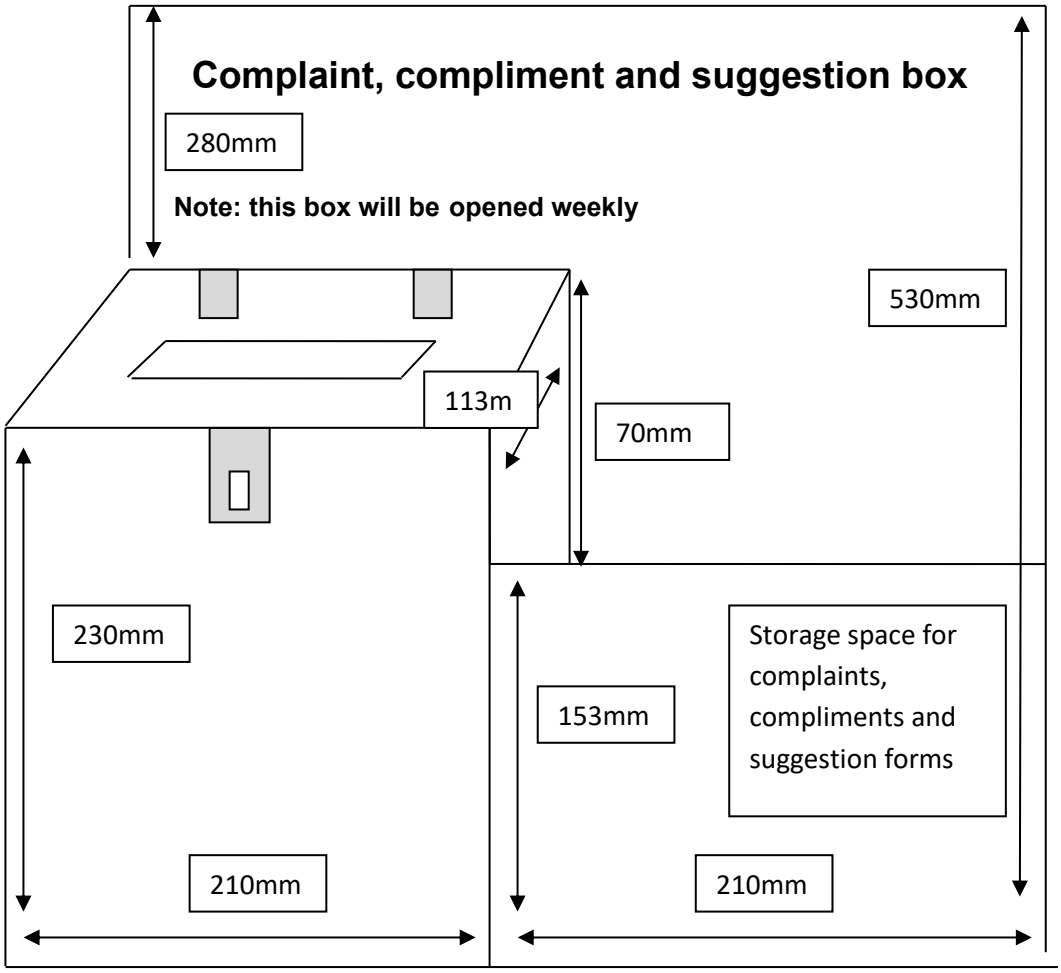
OPERATIONAL PLAN					
PRIORITY AREA	**INTENTION**	**POSSIBLE SOLUTIONS** (OPERATIONAL ACTIVITIES)	**PERSON RESPONSIBLE FOR SOLUTION** (NAME AND AREA OF WORK)	**DUE DATE**	**MANAGER'S COMMENT** (OUTCOME)
Access					
Availability of medicine					
Safety					
Cleanliness and IPC					
Values and attitudes					
Patient waiting time					

Signed commitment

Facility manager: _____ Sub-district manager: _____

Date: _____ Date: _____

Annexure 58: Example of specifications for a complaint, compliment and suggestion boxes



Specifications

Material	Perspex, 5mm thick
Colour	White, frosted
Hinges and hook and eye	Stainless steel
Label	Perspex print on box itself (no labels) in colour as determined by the province (Colour model CMYK: specify colours) Text and font size: "Complaint, compliment and suggestion box" – Arial 72 Repeat text translated into two other languages according to most prevalent language in the province "Note: this box will be opened weekly" – Arial 32
Lock	Lock with number sequence to lock
Mounted	Must be mounted onto the wall, 1.2m above the ground.

Annexure 59: Complaints, compliments and suggestion form

FORM TO LODGE A COMPLAINT OR RECORD A COMPLIMENT OR SUGGESTION

Date completed		**Ref no**	**(office use)**

Do you want to: Complaint ☐ Give a compliment ☐ Make a suggestion ☐
(mark the applicable box with an X)

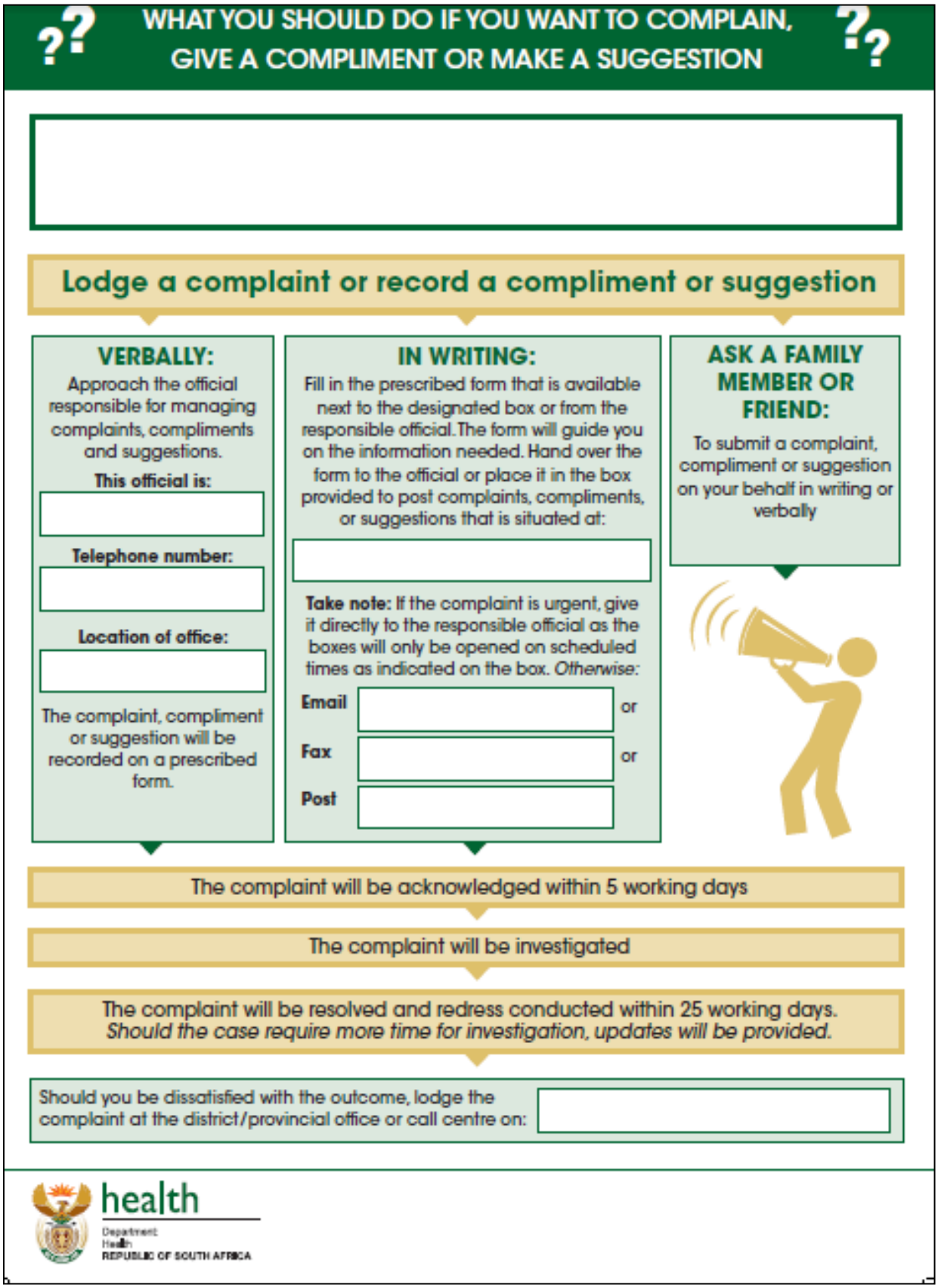
Details of the person lodging a complaint or recording a compliment or suggestion		
Surname		
First Name		
Contact details	Cell number	
	Postal address	
	Physical address	
	E-mail address	
Service area (e.g ward no, reception, pharmacy)		
Hospital or clinic file number		
If you are submitting on behalf of someone else, please complete the following:		
Relation to the patient, e.g. mother, etc.		
Patient's Surname		
Patient's First Name		
Contact details of the patient	Cell number	
	Postal address	
	Physical address	
	E-mail address	
Service area (e.g ward no, reception, pharmacy)		
Patient's hospital or clinic file number		

Please describe the complaint or give a compliment or make a suggestion.
* Where possible also record the staff involved and department where the incident took place.

Date on which the complaint took place:	

_____ _____
Signature of person lodging the complaint Signature of patient

Annexure 60: Complaints, compliments and suggestions poster



Annexure 61: Checklist for element 91: Complaints/compliments/ suggestions toolkit is available at the main entrance/exit

Use the checklist below to check whether the complaint forms, box and poster is available

Scoring - In column for score mark as follows:

Y (Yes) = compliant, **N** (No) = not compliant.

Item	Score
Lockable complaints/compliments/suggestions boxes are visibly placed at main entrance/exit	
Complaints box is mounted (fixed to the wall or flat surface)	
Official complaint/compliment/suggestion forms and pen are at the box at the main entrance/exit	
A standardised poster describing the process to follow to lodge a complaint, give a compliment or make a suggestion is visibly displayed at the entrance of the facility	
A standardised poster describing the process to follow to lodge a complaint, give a compliment or make a suggestion is visibly displayed in a second language commonly spoken official languages	
Total	
Score (Total ÷ 5)	

Annexure 62: Complaint, compliments and suggestion registers

Complaints Register

Health establishment's name: _____ **Month/year: _____**

Ref No. (Column A)	Date received	Acknowledgment date	Number of working days to acknowledge	Patient/ family/ supporting person's name and surname	Patient's name and surname	Service area where complaint was lodged	Summary description of the complaint	Information on i.) action taken, ii) outcome, iii) remedial action	Category of complaint	Severity of complaint (risk rating)	Type of resolution	Date resolved (Column B)	Number of working days to resolve complaint (Column D)

REGISTER FOR COMPLIMENTS

Health establishment's name: _____ **Month/year: _____**

Ref No.	Date Received	Name & surname of person who recorded the compliment	Patient's Name & Surname	Service area where compliment originated from	Summary description of the compliment	Information on action taken

REGISTER FOR SUGGESTIONS

Health establishment's name: _____ **Month/year: _____**

Ref No.	Date Received	Name & surname of person who recorded the suggestion	Patient's Name & Surname	Service area where suggestion originated from	Summary description of the suggestion	Information on action taken

Annexure 63: Statistical data on complaints, compliments and suggestions

Statistical data on Complaints

Name of establishment/province: _____ **Financial year:** _____

Column name	INDICATORS					CATEGORIES													
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
Month:	# Complaints received	# Complaints resolved	% Complaints resolved (Column B÷A)	# Complaints resolved within 25 working days	% Complaints resolved within 25 working days (D÷B)	Staff attitude	Access to information	Physical access	Waiting times	Waiting list	Patient care	Availability of medicines	Safe and secure environment	Hygiene and cleanliness	Linen	Food	Missing patient record	Other	Total per month (Sum of Columns F to R)
April																			
May																			
June																			
Tot Q1																			
Jul																			
Aug																			
Sept																			
Tot Q2																			
Oct																			
Nov																			
Dec																			
Tot Q3																			
Jan																			
Feb																			
March																			
Tot Q4																			
TOTAL																			
AVG (Tot/12)																			
% for financial year (Total of Column F to R ÷ Total Column S)																			

Statistical data on Compliments

Name of establishment/province: _____ **Financial year:** _____

Column name	INDICATOR	CATEGORIES													
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Month:	# Compliment received	Staff attitude	Access to information	Physical access	Waiting times	Waiting list	Patient care	Availability of medicines	Safe and secure environment	Hygiene and cleanliness	Linen	Food	Missing patient record	Other	Total per month (Sum of Columns B to N)
April															
May															
June															
Tot Q1															
Jul															
Aug															
Sept															
Tot Q2															
Oct															
Nov															
Dec															
Tot Q3															
Jan															
Feb															
March															
Tot Q4															
TOTAL															
AVG (Tot/12)															
% for financial year (Total of Column B/C/D/E/F/G/H/I/J/K÷Total Column L)															

Statistical data on Suggestions

Name of establishment/province: _____ **Financial year:** _____

Column name	INDICATOR	CATEGORIES													
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
Month:	# Suggestions received	Staff attitude	Access to information	Physical access	Waiting times	Waiting list	Patient care	Availability of medicines	Safe and secure environment	Hygiene and cleanliness	Linen	Food	Missing patient record	Other	Total per month (Sum of Columns B to N)
April															
May															
June															
Tot Q1															
Jul															
Aug															
Sept															
Tot Q2															
Oct															
Nov															
Dec															
Tot Q3															
Jan															
Feb															
March															
Tot Q4															
TOTAL															
AVG (Tot/12)															
% for financial year (Total of Column B/C/D/E/F/G/H/I/J/K÷Total Column L)															

Annexure 64: Checklist for element 92 - Complaints/ compliments /suggestions records complies with the National Guideline to Manage Complaints/Compliments/ Suggestions

Use the checklist below to check the availability of records required for effective Complaint/Compliment/Suggestion Management

Scoring – in column for score mark as follows:

Check –complaints/compliments/suggestion records for the past three months for statistical data. For complaint letters and redress letter/minutes, check the last five resolved complaints for evidence

Note:

- In cases where no complaints, compliments or suggestions occurred in the past three months. The *Complaints Compliance Report* for the facility as generated from the national web-based information system must show 100% compliance for "Null" reporting for the facility for the past 3 months, facility then score 'NA' at measures marked with a '*'.

Y (Yes) = available; **N** (No) = not available; **NA** (Not applicable) = facility did not receive any complaints/compliments/suggestion in the past 3 months

Item	Score
The facility/district SOP to Manage Complaints/Compliments/Suggestions is available	
* Complaints letters (check the last 5 complaints resolved)	
* Complaints redress letters/minutes (check the last 5 complaints resolved)	
* Complaints register	
* Compliments register	
* Suggestion register	
* Statistical report for indicators and classifications for complaints	
* Statistical report for indicators and classification for compliments	
* Statistical report for indicators and classification for suggestions	
Total	
Total maximum possible score (sum of all scores minus those marked NA)	
Score (Total ÷ Total maximum possible score)	

Annexure 65: Checklist for element 93: Targets set for complaints indicators are met

Use the checklist below to check whether the targets set for the complaints indicators were met

Scoring - in column for score mark as follows:

Check – the previous quarter's data

Y (Yes) = complaint, N (No) = not compliant; Not applicable (NA) = if no complaints were recorded in the previous quarter

Item	Target	Score
Complaint resolution rate	90%	
Complaint resolution rate within 25 working days	90%	
Total score		
Percentage (Score ÷ 2) x 100		**%**

Annexure 66: Checklist for element 95 - SOP for management of availability of medicines is available

Use the checklist below to check whether the SOP for management of availability of medicines describes the topics as listed

Scoring – in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant

Item	Score
Cleaning and appearance of the medicine room/dispensary	
Storage and organisation of the medicine room/dispensary	
Security and control of access to the medicine room/dispensary (within and outside normal working hours)	
Cold chain management	
Emergency cupboard/trolley management	
Management of medicines in the consulting room	
Pest Control	
Calculation and use of minimum, maximum and re-order stock levels	
Completion and management of stock (bin) cards	
Stock taking (counting) procedure	
Management of short-dated stock	
Procurement (ordering) of medicines	
Ordering and delivering schedule for stock	
Receipt of medicines into the medicine room/dispensary (ordered or borrowed stock)	
Managing return of stock to the depot	
Issuing of medicines to the consulting rooms and emergency trolley	
Managing stock transfers between facilities	
Medicine availability monitoring procedure/guide	
Separation and handling of expired, obsolete, unusable or patient-returned medicines (Schedule 0 – 4 medicines)	
Disposal of expired, obsolete, unusable and patient-returned medicines (Schedule 0 – 4 medicines)	
Managing recall of medicines	
Storage and control of Schedule 5 and Schedule 6 medicines	
Separation and disposal of expired, obsolete and unusable medicines (schedule 5 and schedule 6 medicines)	
Total	
Score (Total ÷ 23)	

Note: The topics listed for the SOP can be covered in separate SOPs, it does not need to be one document

Annexure 67: Example of a schedule for acknowledgement of policies/ guidelines/protocols /SOP/notifications

Facility name: _____

Document name: _____

NAME AND SURNAME	PERSAL NUMBER	DESIGNATION	DATE	SIGNATURE

Annexure 68: Cleaning schedule for different areas

NAME OF FACILITY: _____

Key:
Area to be cleaned
Cleaning not applicable to that areas

DAILY DUTIES

Daily duties	Consultation rooms	General and waiting areas	Toilets	Staff kitchen
Wash floor				
Damp dust counter tops				
Wipe door handles				
Wash hand wash basin including taps		Where applicable		
Wash toilets (seats, urinals)				
Wipe soap and paper towel dispensers		Where applicable		
Replenish paper towels				
Replenish toilet paper				
Replenish liquid soap dispensers		Where applicable		
Wash kitchen basin with taps				
Damp dust kitchen equipment				
Spot clean dirty wall surfaces				
Damp dust dressing trolleys				
Damp dust examination lamp				
Damp dust chairs				
General waste bins cleaned and lined with bag				
Medical waste bins/boxes remove when full				
Sharps containers, sealed and removed when 3 quarter full				
Sanitary bins/boxes remove when full				
Remove waste from all service areas to temporary storage area.				
Tie and close all the general waste bags in the temporary storage area.				

WEEKLY DUTIES

Weekly Duties	Consultation rooms	General service and waiting areas	Toilets	Medicine room/ dispensary	All other store rooms
Damp dust window sills					
Wash mirrors					
Damp dust wall skirtings					
Wash floors					
Damp dust counter tops					

MONTHLY DUTIES

Monthly Duties	All areas	Consulting/ vital rooms	Toilets	Staff kitchen	Medicine room/ dispensary	All other storage areas
Wash and wipe signage boards						
Wash inside-out when soap dispensers are empty wash inside and out						
Clean refrigerator						
Wipe out kitchen unit/cupboards						
Damp dust shelves						

QUATERLY DUTIES

Quarterly duties	All areas
Strip all floors and apply polish	
Damp dust light fixtures	
Damp dust ceiling fans	

SIX MONTHLY DUTIES

Six monthly duties	All areas
Wash all the walls from top to bottom	
Wash windows	
Remove, wash and replace all curtains	

Cleaners to report any dysfunctional/missing cleaning equipment immediately to the facility manager or healthcare professional assigned to supervise cleanliness

Annexure 69: Checklist for element 96 - Hand hygiene facilities are available

Use the checklist below to check whether there is running water, liquid hand wash soap and disposable hand paper towels

Scoring - in column for score mark as follows:

Y (Yes) = available, **N** (No) = not available, NA = (*) During drought episodes taps can be closed. Dispensary/medicine room must then have alcohol-based hand rub available. If alcohol-based hand rub is available mark the measure for liquid had wash soap as compliant.

Item	Score
Functional hand wash basin	
Taps are functional with running water (*)	
Liquid hand wash soap	
Disposable hand paper towels	
Poster on hand hygiene is displayed near the hand wash basin	
Total	
Score (Total ÷ 5)	

Annexure 70: Control sheet for sign-off for cleanliness

DAILY AND WEEKLY CHECKLIST FOR CONSULTATION/VITAL ROOMS/WAITING AREAS

Facility name: _____

Month: _____ **Year: _____**

Area	WEEK 1					WEEK 2				
	Monday	Tuesday	Wednes—day	Thursday	Friday	Monday	Tuesday	Wednes-day	Thursday	Friday
Date										
Wash floor										
Damp dust counter tops										
Wipe door handles										
Wash handwash basin including taps										
Wash toilets (seats, urinals)										
Wipe soap and paper towel dispensers										
Replenish paper towels										
Replenish liquid soap dispensers										
Spot clean dirty wall surfaces										
Damp dust dressing trolleys										
Damp dust examination lamp										
Damp dust chairs										
General waste bins cleaned and lined with bag										
Medical waste bins/ boxes remove when full										
Sharps containers, sealed and removed when 3 quarter full										
Damp dust window sills										
Wash mirrors										
Damp dust wall skirting's										
Verification by manager OR delegated healthcare professional that areas are clean										
Signature of manager										
Satisfied (Yes)/Not satisfied (N)										

The cleaner and manager/delegated healthcare professional must sign/initial in the appropriate space. Manager/delegated healthcare professional must also indicate the level of satisfaction.

DAILY AND WEEKLY CHECKLIST FOR CONSULTATION/VITAL ROOMS/WAITING AREAS

Facility name: _____

Month: _____ **Year: _____**

Area	WEEK 3					WEEK 4				
	Monday	Tuesday	Wednes—day	Thursday	Friday	Monday	Tuesday	Wednes-day	Thursday	Friday
Date										
Wash floor										
Damp dust counter tops										
Wipe door handles										
Wash handwash basin including taps										
Wash toilets (seats, urinals)										
Wipe soap and paper towel dispensers										
Replenish paper towels										
Replenish liquid soap dispensers										
Spot clean dirty wall surfaces										
Damp dust dressing trolleys										
Damp dust examination lamp										
Damp dust chairs										
General waste bins cleaned and lined with bag										
Medical waste bins/ boxes remove when full										
Sharps containers, sealed and removed when 3 quarter full										
Damp dust window sills										
Wash mirrors										
Damp dust wall skirting's										
Verification by manager OR delegated healthcare professional that areas are clean										
Signature of manager										
Satisfied (Yes)/Not satisfied (N)										

The cleaner and manager/delegated healthcare professional must sign/initial in the appropriate space. Manager/delegated healthcare professional must also indicate the level of satisfaction.

MONTHLY/QUARTERLY/SIX MONTHLY CHECKLIST FOR CONSULTATION/VITAL ROOMS/WAITING AREAS

Facility name: _____

Year: _____

Duties	Jan	Feb	Mrt	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Wash inside-out when soap dispensers are empty												
Strip all floors and apply polish												
Damp dust light fixtures												
Damp dust ceiling fans												
Wash all the walls from top to bottom												
Wash windows												
Remove, wash and replace all curtains												
Verification by manager OR delegated healthcare professional that areas are clean												
Signature of manager												
Satisfied (Yes)/Not satisfied (N)												

The cleaner and manager/delegated healthcare professional must sign/initial in the appropriate space. Manager/delegated healthcare professional must also indicate the level of satisfaction.

WEEKLY AND DAILY CHECKLIST FOR MEDICINE ROOM/DISPENSARY

Facility name: _____

Month: _____ **Year: _____**

Area	WEEK 1					WEEK 2				
	Monday	Tuesday	Wednes-day	Thursday	Friday	Monday	Tuesday	Wednes-day	Thursday	Friday
Date										
Wash floors										
Damp dust counter tops										
Damp dust window sills										
Damp dust wall skirting's										
Verification by manager OR delegated healthcare professional that areas are clean										
Signature of manager										
Satisfied (Yes)/Not satisfied (N)										

Area	WEEK 3					WEEK 4				
	Monday	Tuesday	Wednes-day	Thursday	Friday	Monday	Tuesday	Wednes-day	Thursday	Friday
Date										
Wash floors										
Damp dust counter tops										
Damp dust window sills										
Damp dust wall skirting's										
Verification by manager OR delegated healthcare professional that areas are clean										
Signature of manager										
Satisfied (Yes)/Not satisfied (N)										

The cleaner and manager/delegated healthcare professional must sign/initial in the appropriate space. Manager/delegated healthcare professional must also indicate the level of satisfaction.

Checklist for medicine/dispensing room for monthly/quarterly/six monthly cleaning duties

Facility name: _____

Year: _____

Duties	Jan	Feb	Mrt	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Wash inside-out when soap dispensers are empty												
Damp dust shelves												
Strip all floors and apply polish												
Damp dust light fixtures												
Damp dust ceiling fans												
Wash all the walls from top to bottom												
Wash windows												
Remove, wash and replace all curtains												
Clean refrigerator												
Verification by manager OR delegated healthcare professional that areas are clean												
Signature of manager												
Satisfied (Yes)/Not satisfied (N)												

The cleaner and manager/delegated healthcare professional must sign/initial in the appropriate space. Manager/delegated healthcare professional must also indicate the level of satisfaction.

DAILY CHECKLIST FOR TOILETS

Facility name: _____

Date:_____

Area	Monday		Tuesday		Wednesday		Thursday		Friday	
	Time		Time		Time		Time		Time	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Wash Floor										
Clean basins										
Wash mirrors										
Wipe door handles										
Clean toilets										
Clean urinals										
Clean sanitary bins										
Clean general bins and line with bag										
Remove bins that are full										
Replenish disposable towels										
Replenish soap										
Replenish toilet paper										
Verification by manager OR delegated healthcare professional that areas are clean										
Signature of manager										
Satisfied (Y)/Not satisfied (N)										

The cleaner and manager/delegated healthcare professional must sign/initial in the appropriate space. Manager/delegated healthcare professional must also indicate the level of satisfaction.

WEEKLY CHECKLIST FOR TOILETS

Facility name: _____

Month: _____ **Year: _____**

Area	WEEK 1					WEEK 2				
	Monday	Tuesday	Wednes-day	Thursday	Friday	Monday	Tuesday	Wednes-day	Thursday	Friday
Date										
Damp dust window sills										
Wash mirrors										
Damp dust wall skirting's										
Verification by manager OR delegated healthcare professional that areas are clean										
Signature of manager										
Satisfied (Yes)/Not satisfied (N)										

Area	WEEK 2					WEEK 3				
	Monday	Tuesday	Wednes-day	Thursday	Friday	Monday	Tuesday	Wednes-day	Thursday	Friday
Date										
Damp dust window sills										
Wash mirrors										
Damp dust wall skirting's										
Verification by manager OR delegated healthcare professional that areas are clean										
Signature of manager										
Satisfied (Yes)/Not satisfied (N)										

The cleaner and manager/delegated healthcare professional must sign/initial in the appropriate space. Manager/delegated healthcare professional must also indicate the level of satisfaction.

MONTHLY/QUARTERLY/SIX MONTHLY CHECKLIST FOR TOILETS

Facility name: _____

Year: _____

Duties	Jan	Feb	Mrt	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Wash inside-out when soap dispensers are empty												
Damp dust light fixtures												
Wash all the walls from top to bottom												
Wash windows												
Verification by manager OR delegated healthcare professional that areas are clean												
Signature of manager												
Satisfied (Yes)/Not satisfied (N)												

The cleaner and manager/delegated healthcare professional must sign/initial in the appropriate space. Manager/delegated healthcare professional must also indicate the level of satisfaction.

DAILY AND WEEKLY CHECKLIST FOR STAFF KITCHEN

Facility name: _____

Month: _____ **Year: _____**

Area	WEEK 1					WEEK 2				
	Monday	Tuesday	Wednes-day	Thursday	Friday	Monday	Tuesday	Wednes-day	Thursday	Friday
Date										
Wash floors										
Damp dust window sills										
Damp dust wall skirting's										
Verification by manager OR delegated healthcare professional that areas are clean										
Signature of manager										
Satisfied (Yes)/Not satisfied (N)										

Area	WEEK 3					WEEK 4				
	Monday	Tuesday	Wednes-day	Thursday	Friday	Monday	Tuesday	Wednes-day	Thursday	Friday
Date										
Wash floors										
Damp dust window sills										
Damp dust wall skirting's										
Verification by manager OR delegated healthcare professional that areas are clean										
Signature of manager										
Satisfied (Yes)/Not satisfied (N)										

The cleaner and manager/delegated healthcare professional must sign/initial in the appropriate space. Manager/delegated healthcare professional must also indicate the level of satisfaction.

MONTHLY/QUARTERLY/SIX MONTHLY CHECKLIST FOR STAFF KITCHEN

Facility name: _____

Year: _____

Duties	Jan	Feb	Mrt	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Strip all floors and apply polish												
Damp dust light fixtures												
Damp dust ceiling fans												
Wash all the walls from top to bottom												
Wash windows												
Clean refrigerator												
Wipe out kitchen unit/ cupboards												
Verification by manager OR delegated healthcare professional that areas are clean												
Signature of manager												
Satisfied (Yes)/Not satisfied (N)												

The cleaner and manager/delegated healthcare professional must sign/initial in the appropriate space. Manager/delegated healthcare professional must also indicate the level of satisfaction.

Annexure 71: Checklist for element 100 - Medicine/ dispensary room and waiting area are clean

Use the checklist below to check whether the areas are clean

Scoring – in column for score mark as follows:

Check – the medicine/dispensary room and the waiting area for the medicine/dispensary room

Y (Yes) = compliant; **N** (No) = not compliant, **NA** = Facility do not have all the areas

Area and measures	**Score**	**Score**
CONSULTING ROOMS:	**Medicine/dispensary room**	**Waiting area**
Windows are clean		
Window sills are clean		
Floor is clean		
Wall skirtings are free of dust		
Countertops are clean		
Door handles are clean		
Walls are clean		
Bins are not overflowing		
Bins are clean		
Areas are odour-free		
Areas are free of cobwebs		
Total		
Total maximum possible score (sum of all scores minus those marked NA)		
Score (Total ÷ Total maximum possible score)		

Annexure 72: Example of a system to organise medicine in the medicine room

1. Pharmaceutical stock may be arranged according to the provincial clinic order list, by dosage form (e.g. tablets/capsules, liquids, injections, topical preparations etc) or in categories per disorder (e.g. diabetes, asthma, epilepsy, TB, HIV).
2. The applicable SOP and space available in the medicine room must be taken into consideration when deciding which approach to use.
3. Store items by generic name.
4. Label brazier bins or shelves neatly.
5. A colour coding system may be used to assist in the identification of medicines. The same colour coding used in the medicine room should be used in the organization of medicine stored in the consulting room/s. Refer Table 1 for an example of a colour coding system.
6. Pack stock in the designated storage location (brazier bin) for the item.
7. Stock must be stored and rotated using FEFO/FIFO principles.
8. Expired, damaged and obsolete stock must be removed from the shelves and stored in a separately designated area and disposed of according to approved procedures

Table 1: colour coding for brazier bins

CATEGORY	COLOUR	COLOUR INDICATION
ANTIBIOTICS	ORANGE	ORANGE
ACUTE AILMENTS	NEON YELLOW	NEON YELLOW
ANTENATAL	NEON PINK	NEON PINK
ASTHMA	BLUE	BLUE
DIABETES	LIGHT BLUE	LIGHT BLUE
EPILEPSY	LIGHT PURPLE	LIGHT PURPLE
FAMILY PLANNING	LIGHT PINK	LIGHT PINK
HEART & HYPERTENSION	RED	RED
HIV	GREEN	GREEN
TB	YELLOW	YELLOW
PAIN	PINK	PINK

NOTE: These colour indications are for the various categories of medicine, as per the provincial ordering list.

Example of a medicine room/dispensary with a colour coding system to organise the medicine

Annexure 73: Checklist for element 101 - Medicine room/dispensary is neat and medicines are stored to maintain quality

Use the checklist below to check how the facility stores medicine to ensure that quality medicines are available

Scoring – in column for score mark as follows:

Y (Yes) = if present and compliant; **N** (No) = if not present or not compliant

Item	Score
Access to the dispensary/medicine room is controlled at all times	
There are no cracks, holes or signs of water damage in the dispensary/medicine room	
There is sufficient space in the dispensary/medicine room to store medicines needed in the facility	
There are no medicines stored in direct contact with the floor	
There is no evidence of pests in the dispensary/medicine room	
Medicines are stored neatly on shelves	
Medicines are stored according to a classification system	
Brazier bins (storage organisers) are neatly labelled	
Medicines are packed according to FEFO (First Expired, First Out) principles	
Total score	
Percentage (Total score ÷ 9) x 100	**%**

Annexure 74: Example of a temperature control chart for medicine room/dispensary

DAILY MEDICINE ROOM/DISPENSARY TEMPERATURE RECORD

FACILITY _____ **DISTRICT** _____

MONTH/YEAR _____

RECORD TEMPERATURE DAILY

DAY	TEMPERATURE (°C)	COMMENT*	DAY	TEMPERATURE (°C)	COMMENT*
1			17		
2			18		
3			19		
4			20		
5			21		
6			22		
7			23		
8			24		
9			25		
10			26		
11			27		
12			28		
13			29		
14			30		
15			31		
16					

_____ _____

Signature of supervisor Date:

**** Indicate action taken when the temperature recorded exceeds 25 °C under the comments section.***

Action to take when the room temperature exceeds 25 °C:

1. Check that the air conditioner is on. If not, check the electricity supply to the air conditioner and switch the air conditioner on.
2. If there are no challenges with the electricity supply but the air conditioner is not on **OR** if the air conditioner is on but not in good working order, place an urgent works/procurement order for repairs/replacement using district procurement procedures.
3. Open windows and use electrical fans where available to reduce the temperature until air conditioner is functional

Annexure 75: Checklist for element 102: Temperature of the medicine room/dispensary is maintained within the safety range

Use the checklist below to check whether the medicine in the medicine room/dispensary is maintained within the safety range

Scoring - in column for score mark as follows:

Y (Yes) = comply, **N** (No) = do not comply,

Item	**Score**
There is a functional air conditioner	
There is at least one functional, wall-mounted room thermometer	
The temperature of the pharmacy is recorded daily	
The temperature of the pharmacy is maintained within the safety range	
Total score	
Percentage (Total score ÷ 4) x 100	**%**

Annexure 76: Example of a temperature control chart for medicine refrigerator

DAILY REFRIGERATOR TEMPERATURE RECORD

FACILITY _____ **MONTH/YEAR** _____ **DISTRICT** _____

Record temperature at 08:00 and 15:00 daily

Day		1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
Deg. °C		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
UNSAFE	22																																																													
	20																																																														
	18																																																													
	16																																																													
	14																																																													
	12																																																													
	10																																																													
SAFE	8																																																												
	6																																																												
	4																																																												
	2																																																												
UNSAFE	0																																																												
	-2																																																												
	-4																																																												
	-8																																																												
	-10																																																												
DEFROST																																																													

**** Indicate in the 'Defrost' section of the temperature chart the date and time when the fridge is defrosted.***

_____ _____

Signature of supervisor Date:

Action to take when the temperature moves into the "UNSAFE" range:

1. Check the electricity supply connection. Check the gas supply – is there a spare gas cylinder?
2. Check that the door closes properly. Check that the door has not been left open for a while. Check how often the fridge door is opened. Make sure that the fridge is not overloaded.
3. Check how thick the ice build-up is in the freezing compartment. **DEFROST IF THE ICE IS MORE THAN 0.5CM THICK** – CLEAN THE FRIDGE REGULARLY.
4. Implement your contingency plan if the fridge is malfunctioning. Notify your supervising pharmacist, sub-district and/or district pharmacy and PHC managers of the challenge.

Annexure 77: Checklist for element 103 - Cold chain procedure for vaccines is maintained

Use the checklist below to check whether the cold chain for vaccines is maintained

Scoring – in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant

Item	Score
Facility has a vaccine or medicine refrigerator with a thermometer	
The temperature of the refrigerator is recorded twice daily, 7 hours apart (check one month's record)	
The temperature of the refrigerator is maintained between 2-8 ºC (check one month's record)	
There is a cooler box for storage of vaccines if needed	
Ice packs are available for use as needed	
Total score for all	
Percentage (Total score ÷ 5) x 100	**%**

Annexure 78: Checklist for element 104 - Medicine cupboard or trolley is neat and orderly

Use the checklist below to check whether the medicine cupboard or trolley is neat and orderly

Scoring – in column for score mark as follows:

Check – randomly select two consultation rooms (if the facility has only one, score this) and check whether the medicine cupboard or trolley complies with measures

Y (Yes) = compliant; **N** (No) = not compliant

Item	Score Consultation room 1	Score Consultation room 2
Surfaces inside the cupboard/trolley are clean		
Medicines are neatly grouped together according to a classification system e.g. by dosage form (tablets/capsules, liquids, ointments, drops etc.) in alphabetical order and by generic name		
Medicine packets/bottles are clean and dust free		
There are no loose tablets or vials lying around		
There are no used unsheathed needles lying around or placed in open vials		
Total Score		
Total Maximum possible score (sum of all scores minus the ones marked NA)		
Percentage (Total score ÷ Total maximum possible score) x 100	**%**	

Annexure 79: Register for schedule 5 and 6 medicines

Schedule 5 and 6 Medicine Register

ISSUED AND RECEIVED		Medicine				Strength					Pack size	
				Balance	Name of patient	Patient No	Date	Time	Dose given	Prescriber	Signature Rank of person administering	Signature Rank of person checking*
	Requisition/ order number											
	Signature of pharmacist											
	Signature of registered nurse											
	Strength											
	Quantity issued											
	Medicine											
	Date											

Annexure 80: Checklist for element 107 - Electronic networked system for monitoring the availability of medicine is used effectively

Use the checklist below to check whether the electronic networked system for monitoring the availability of medicines is used appropriately

Scoring – in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant; **NA** = as indicated

Item	Score
The facility has functional electronic networked system for monitoring the availability of medicines	
The approved list of medicines to be updated is visible in the medicine room	
The capturing device is in good working order	
The accessories for the capturing device is in good working order (only applicable to SVS)	
The capturing device and its accessories are stored in a lockable unit (only applicable to SVS)	
Access to the keys for the unit where the capturing device is kept is restricted (only applicable to SVS)	
The facility has not been marked as non-reporting for two weeks (7 working days) or more (at the point of assessment)* (only applicable to SVS)	
Total	
Total maximum possible score (sum of all scores minus those marked NA)	
Score (Total ÷ Total maximum possible score)	

** For facilities using the stock visibility system (SVS) the source for this information will be the website used to view captured medicine availability data and the Primary Health Care Facility Dashboard associated with it.*

Annexure 81: Essential Medicines List for Primary Health Care Facilities

ATC	MEDICINE	ATC	MEDICINE
A02BC	Proton-pump inhibitor, oral	B05XA05	Magnesium sulphate, parenteral
A02BC03	Lansoprazole, oral	C01CA24	Epinephrine (adrenaline), parenteral
A03BA01	Atropine, parenteral	C01DA	Nitrates, short acting, oral
A03BB01	Hyoscine butylbromide, oral	C01DA08	Isosorbide dinitrate, oral
A03FA01	Metoclopramide, oral	C01DA14	Isosorbide mononitrate, oral
A03FA01	Metoclopramide, parenteral	C02AB01	Methyldopa, oral
A06AB06	Sennosides A and B, oral	C03AA	Thiazide Diuretic
A06AD11	Lactulose, oral	C03AA03	Hydrochlorothiazide, oral
A07AA02	Nystatin, oral	C03C	Loop Diuretic, oral
A07BA01	Charcoal, activated	C03C	Loop Diuretic, parenteral
A07CA	Oral rehydration solution (ORS)	C03CA01	Furosemide, oral
A07DA03	Loperamide, oral	C03CA01	Furosemide, parenteral
A10AB	Insulin, short/rapid acting	C03DA01	Spironolactone, oral
A10AC	Insulin, intermediate acting	C05AX02	Bismuth subgallate compound, topical
A10AD	Insulin, biphasic	C07A	ß-blocker, oral
A10BA02	Metformin, oral	C07AB11	Atenolol, oral
A10BB	Sulphonylureas, oral	C07AG	Alpha 1 and non-selective ß blocker, oral
A10BB01	Glibenclamide, oral	C07AG02	Carvedilol, oral
A10BB12	Glimepiride, oral	C08CA	Calcium channel blocker, long acting, oral
A11B	Multivitamin, oral	C08CA01	Amlodipine, oral
A11CA01	Vitamin A (retinol), oral	C08CA05	Nifedipine, short-acting, oral
A11DA01	Thiamine (vit B1), oral	C09A	ACE-Inhibitor, oral
A11EA	Vitamin B Complex, oral	C09AA02	Enalapril, oral
A11HA01	Nicotinamide (vitamin B3), oral	C10AA	HMGCoA reductase inhibitors (statins), oral
A11HA02	Pyridoxine (vit B6), oral	C10AA01	Simvastatin, oral
A12AA04	Calcium carbonate, oral	D01AC	Imidazole, topical
A12CB	Zinc, elemental, oral	D01AC01	Clotrimazole, topical
B01AC06	Aspirin, oral	D01AE12	Salicylic Acid, topical
B01AD01	Streptokinase, parenteral	D01AE13	Selenium sulphide, topical
B02BA01	Vitamin K1 (phytomenodione), parenteral	D02A	Emollient
B03A	Iron, oral	D02AB	Zinc and caster oil ointment
B03AA	Ferrous lactate, oral	D02AC	Petroleum Jelly
B03AA02	Ferrous fumarate, oral	D02AX	Aqueous cream (UEA)
B03AA03	Ferrous gluconate, oral	D02AX	Emulsifying ointment
B03AD03	Ferrous sulphate compound (BPC), oral	D04AB01	Lidocaine, topical
B03BB01	Folic Acid, oral	D04AB06	Tetracaine, topical
B05BA03	Dextrose, I.V. solution	D04AX	Calamine lotion
B05BB01	Sodium Chloride 0.9%, I.V. solution	D05AA	Coal Tar (LPC), topical
B05CB01	Sodium Chloride 0.9%, irrigation	D07AA02	Hydrocortisone, topical

ATC	MEDICINE	ATC	MEDICINE

D07AC01	Betamethasone, topical	H03AA01	Levothyroxine, oral
D08AC02	Chlorhexidine, topical	J01AA02	Doxycycline, oral
D08AG02	Povidone iodine, topical	J01CA01	Ampicillin, parenteral
D08AG03	Iodine tincture BP, topical	J01CA04	Amoxicillin, oral
D09AA	Bismuth iodoform paraffin paste (BIPP), topical	J01CE02	Phenoxymethylpenicillin, oral
D09AX	Paraffin gauze dressings	J01CE08	Benzathine benzylpenicillin (depot formulation), parenteral
D10AD	Retinoids, topical	J01CF05	Flucloxacillin, oral
D10AD01	Tretinoin, topical	J01CR02	Amoxicillin/Clavulanic Acid, oral
D10AE01	Benzoyl peroxide, topical	J01DB01	Cephalexin, oral
G01AF02	Clotrimazole, vaginal	J01DD04	Ceftriaxone, parenteral
G02AB03	Ergometrine, parenteral	J01EE01	Trimethoprim/Sulfamethoxazole (Cotrimoxazole), oral
G02AD06	Misoprostol	J01FA	Macrolide, oral
G02BA02	Copper IUD	J01FA01	Erythromycin, oral
G03A	Contraceptives. Hormonal for systemic use	J01FA10	Azithromycin, oral
G03AA	Contraceptives, monophasic: combined estrogen/progestin pill	J01GB04	Kanamycin, parenteral
G03AA07	Ethinyloestradiol/levonorgestrel 30mcg/150 mcg, oral	J01MA	Fluoroquinolone, oral
G03AB	Contraceptives, triphasic: combined estrogen/progestin pill	J01MA02	Ciprofloxacin, oral
G03AB03	Levonorgestrel/Ethinyl oestradiol, oral	J01MA14	Moxifloxacin, oral
G03AC	Contraceptives, levonorgestrel, implant	J01XD01	Metronidazole, oral
G03AC	Contraceptives, monophasic: progestin only pill	J02AC01	Fluconazole, oral
G03AC	Contraceptives, progestin only pill	J04AB02	Rifampicin (R), oral
G03AC	Contraceptives, progestin-only injectable, parenteral	J04AC01	Isoniazid (H/INH), oral
G03AC	Contraceptives, progestin-only subdermal implant	H03AA01	Levothyroxine, oral
G03AC03	Levonorgestrel pill	J01AA02	Doxycycline, oral
G03AC06	Contraceptives, medroxyprogesterone acetate depot, parenteral	J01CA01	Ampicillin, parenteral
G03AC08	Etonogestrel, implant	J01CA04	Amoxicillin, oral
G03AD	Progestin-only, emergency contraceptive, oral	J01CE02	Phenoxymethylpenicillin, oral
G03AD01	Levonorgestrel, emergency contraceptive, oral	J01CE08	Benzathine benzylpenicillin (depot formulation), parenteral
G03C	Estrogen, oral	J01CF05	Flucloxacillin, oral
G03CA03	Estradiol valerate, oral	J01CR02	Amoxicillin/Clavulanic Acid, oral
G03CA57	Estrogens conjugated, oral	J01DB01	Cephalexin, oral
G03DA02	Medroxyprogesterone acetate, oral	J01DD04	Ceftriaxone, parenteral
G03DC02	Norethisterone acetate, oral	J01EE01	Trimethoprim/Sulfamethoxazole (Cotrimoxazole), oral
G03HA01	Cyproterone acetate, oral	J01FA	Macrolide, oral
H01BB02	Oxytocin, parenteral	J01FA01	Erythromycin, oral
H01BB02/ G02AB03	Oxytocin/ergometrine, parenteral	J01FA10	Azithromycin, oral
H02AB01	Betamethasone, parenteral	J01GB04	Kanamycin, parenteral
H02AB07	Prednisone, oral	J01MA	Fluoroquinolone, oral
H02AB09	Hydrocortisone, parenteral	J01MA02	Ciprofloxacin, oral

ATC	MEDICINE	ATC	MEDICINE
J01MA14	Moxifloxacin, oral	M02AC	Methyl Salicylate Ointment

J01XD01	Metronidazole, oral	M04AA01	Allopurinol, oral
J02AC01	Fluconazole, oral	N01AX13	Nitrous Oxide, general anesthetic
J04AB02	Rifampicin (R), oral	N01BB02	Lidocaine 1%, parenteral
J04AC01	Isoniazid (H/INH), oral	N01BB02	Lidocaine 2%, parenteral
J04AD03	Ethionamide, oral	N01BB52	Lidocaine with epinephrine (adrenaline), parenteral
J04AK01	Pyrazinamide (Z), oral	N02AA01	Morphine, parenteral
J04AK02	Ethambutol (E), oral	N02AA01	Morphine, oral
J04AK03	Terizidone, oral	N02AB02	Pethidine, parenteral
J04AM02	Rifampicin/Isoniazid (RH), oral	N02AX02	Tramadol, oral
J04AM06	Rifampicin/Isoniazid/Pyrazinamide/Ethambutol (RHZE), oral	N02BE01	Paracetamol, oral
J05AB01	Aciclovir, oral	N03AA02	Phenobarbital (phenobarbitone), oral
J05AE03	Ritonavir, oral	N03AB02	Phenytoin, oral
J05AE08/ J05AE03	Atazanavir/ritonavir, oral	N03AE	Benzodiazepines (antiepileptics)
J05AF01	Zidovudine, oral	N03AF01	Carbamazepine, oral
J05AF05	Lamivudine, oral	N03AG01	Valproate, oral
J05AF06	Abacavir, oral	N03AX09	Lamotrigine, oral
J05AF07	Tenofovir, oral	N04A	Anticholinergic agents, oral
J05AF09	Emtricitabine, oral	N04A	Anticholinergic agents, parenteral
J05AG01	Nevirapine, oral	N04AA02	Biperiden, parenteral
J05AG03	Efavirenz, oral	N04AB02	Orphenadrine, oral
J05AR10/J05AE03	Lopinavir/ritonavir, oral	N05AA01	Chlorpromazine, oral
J06BB01	Anti-D immunoglobulin	N05AB02	Fluphenazine decanoate, parenteral
J06BB05	Rabies Immunoglobulin (RIG)	N05AD01	Haloperidol, parenteral
J07AG01	Haemophilus Influenzae Type B (Hib) vaccine	N05AD01	Haloperidol, oral
J07AL02	Pneumococcal conjugated vaccine (PCV)	N05AF01	Flupenthixol decanoate, parenteral
J07AM01	Tetanus toxoid (TT)	N05AF05	Zuclopenthixol acetate, parenteral
J07AM51	Tetanus and diptheria (Td) vaccine	N05AF05	Zuclopenthixol decanoate, parenteral
J07AM51	Diptheria, tetanus and pertussis(DTP) vaccine	N05AX08	Risperidone, oral
J07BB	Influenza vaccine	N05BA	Benzodiazepines (anxiolytics)
J07BC01	Hepatitis B (HepB) vaccine	N05BA01	Diazepam, oral
J07BD01	Measles vaccine	N05BA01	Diazepam, parenteral
J07BF	Oral polio vaccine (OPV)	N05CD	Benzodiazepines (sedatives)
J07BG01	Rabies vaccine	N05CD08	Midazolam, parenteral
J07BH	Rotavirus vaccine	N06AA	Tricyclic antidepressants, oral
J07CA09	Hexavalent - diptheria, tetanus, acellular pertussis, inactivated polio, hepatitis B, haemophilus influenza type b vaccine	N06AA09	Amitriptyline, oral
L03AX03	Bacillus Calmette-Guerin (BCG) vaccine	N06AB	Selective serotonin reuptake inhibitors (SSRIs), oral
M01A	NSAID, oral	N06AB03	Fluoxetine, oral
M01AE01	Ibuprofen, oral	N06AB04	Citalopram, oral

ATC	MEDICINE	ATC	MEDICINE
P01AB01	Metronidazole, oral		
P01BC01	Quinine dihydrochloride, parenteral		

P01BE03	Artesunate, parenteral		
P01BF01	Artemether/lumefantrine, oral		
P02BA01	Praziquantel, oral		
P02CA01	Mebendazole, oral		
P02CA03	Albendazole, oral		
P03AC04	Permethrin, topical		
P03AX01	Benzyl benzoate, topical		
R01AA05	Oxymetazoline, nasal		
R01AA14	Epinephrine (adrenaline), inhalation		
R01AD	Corticosteroid, nasal		
R01AD05	Budesonide, nasal		
R03AC	ß$_2$ agonist, short acting, inhaler		
R03AK	Long-acting beta$_2$ agonist/corticosteroid combination, inhaler		
R03AK06	Salmeterol/fluticasone, inhaler		
R03BA	Corticosteroids, inhaled		
R03BA01	Beclomethasone, inhaler		
R03BB01	Ipratropium Bromide, inhaler		
R03AC02	Salbutamol, inhaler		
R05	Cough Syrup		
R06AB04	Chlorphenamine, oral		
R06AD02	Promethazine, parenteral		
R06AE07	Cetirizine, oral		
S01AA01	Chloramphenicol, opthalmic		
S01EC01	Acetazolamide, oral		
S01FA01	Atropine, opthalmic		
S01GA04	Oxymetazoline, opthalmic		
S01GX01	Sodium Cromoglycate, opthalmic		
S01HA03	Tetracaine (amethocaine), opthalmic		
S01XA03	Sodium Chloride, hypertonic, I.V. solution		
S02AA10	Acetic acid in alcohol 2%, otological		
V03AB15	Naloxone, parenteral		
V03AN01	Oxygen		
V06DC01	Dextrose, oral		
V07AB	Water for injection/ sterile water, parenteral		

Annexure 82: Checklist for element 109 - Medicines on the tracer medicine list are available

Availability of tracer medicines listed below should be measured on an electronic networked stock availability monitoring system

Scoring – where an electronic networked stock availability monitoring system is not available, use the scoring columns in the list below to score availability as follows:

Check – available stock in the medicine room/dispensary

Y (Yes) = available, not expired; **N** (No) = not available OR available but expired; **NA** (Not Applicable) = where the medicine is required for a specific service provided at the CHC, e.g. treatment of HIV/TB and the CHC do not provide the specific service as they only provide services for screening of HIV/TB; * = Only required at midwife obstetric units; ** = Required for facilities, where there is a permanent doctor; *** = Relevant where malaria cases are prevalent.

MEDICINE ROOM/DISPENSARY			
Oral formulations/inhalers			
	Score		**Score**
Abacavir 20mg/ml solution OR Abacavir 60 mg dispersible tablets OR Abacavir/Lamivudine 120/60 mg dispersible tablets		Lopinavir, Ritonavir 200/50mg tablets OR Atazanavir, Ritonavir 300/100mg OR tazanavir 150mg capsules WITH Ritonavir 100mg capsules	
Abacavir 300mg tablets		Lopinavir, Ritonavir 80/20mg/ml solution OR Lopinavir, Ritonavir 40/10mg capsules (pellets) OR sachets (granules)	
Amoxicillin 250mg OR 500mg capsules		Metformin 500mg OR 850mg tablets	
Amoxicillin 125mg/5ml OR 250mg/5ml suspension		Methyldopa 250 mg tablets	
Azithromycin 250mg OR 500mg tablets		Metronidazole 200mg OR 400mg tablets	
Beclomethasone/Budesonide 100mcg OR 200 mcg metered dose inhaler (MDI)		Nevirapine 200mg tablets	
Carbamazepine 200mg tablets OR Lamotrigine 25mg tablets		Nevirapine 50mg/5ml suspension	
Co-trimoxazole 200/40mg per 5ml suspension		Oral rehydration solution	
Co-trimoxazole 400/80mg tablets		Paracetamol 120mg/5ml syrup	
Dolutegravir 50 mg capsule		Paracetamol 500mg tablets	
Enalapril 5mg or 10mg tablets		Prednisone 5mg tablets OR Prednisolone 5mg tablets	
Ethambutol 400mg tablets		Pyrazinamide 500mg tablets	
Ferrous lactate/gluconate liquid/syrup		Pyridoxine 25mg tablets	
Ferrous sulphate (dried) /fumarate tablets providing ± 55 to 65mg elemental iron		Rifampicin + Isoniazid (RH) 300mg/150mg OR 150/75mg tablets	
Folic acid 5 mg tablets		Rifampicin + Isoniazid (RH) 60/60 tablets OR Rifampicin + Isoniazid (RH) 75/50 tablets OR Rifampicin + Isoniazid (RH) + pyrazinamide (RHZ) 75/50/150 tablets	
Hydrochlorothiazide 12.5mg OR 25mg tablets		Rifampicin + Isoniazid + pyrazinamide + ethambutol (RHZE) 150/75/400/275 tablets	
Ibuprofen 200 mg OR 400mg tablets		Salbutamol 100 mcg MDI	
Isoniazid 100mg OR 300mg tablets		Simvastatin 10mg OR 20mg OR 40mg tablets	
Lamivudine 10mg/ml syrup/solution		Tenofovir/emtricitabine 300/200 mg tablets	
Lamivudine 150mg tablets		Tenofovir/emtricitabine/efavirenz 300/200/600mg tablets	
Combined oral contraceptive pill containing 30 mcg ethinylestradiol		Tenofovir/ lamivudine /dolutegravir 300/300/50mg tablets	

ethinylestradiol/levonorgestrel OR ethinylestradiol/norethisterone OR ethinylestradiol/gestodene OR ethinylestradiol/norgestimate		Vitamin A 50,000U OR 100,000U OR 200,000U capsules	
		Zidovudine 50mg/5ml, solution/suspension	
Injections			
	Score		**Score**
Benzathine benzylpenicillin 1.2MU OR 2.4MU vial		Medroxyprogesterone acetate 150mg/ml OR Norethisterone 200mg/ml injections	
Ceftriaxone 250mg OR 500mg OR 1g vials		Gentamicin 80mg/2ml 2ml ampoule OR Fosfomycin 3g granules	
Topicals			
	Score		**Score**
Chloramphenicol 1%, ophthalmic ointment			
Fridge			
	Score		**Score**
BCG vaccine		Pneumococcal Conjugated Vaccine (PCV)	
Insulin, short acting		Polio vaccine (oral)	
Measles vaccine		Rotavirus vaccine	
Hexavalent: DTaP-IPV-HB-Hib vaccine		Tetanus toxoid (TT) vaccine	
Oxytocin 5 OR 10 IU/ml		Ergometrine 0.5mg OR oxytocin/ ergometrine 5U/0.5mg combination*	
Emergency trolley			
	Score		**Score**
Activated Charcoal		Lidocaine/Lignocaine IM 1% OR 2% 20ml vial	
Adrenaline 1mg/ml (Epinephrine) 1ml ampoule		Magnesium sulfate 50%, 1g/2ml ampoule (minimum of 14 ampoules required for one treatment)	
Amlodipine 5mg OR 10mg tablets		Midazolam (1mg/ml 5ml ampoule OR 5mg/ml) 3ml ampoule) OR Diazepam 5mg/ml 2ml ampoule	
Artesunate 60mg injection***		Nifedipine 5mg OR 10mg capsules	
Aspirin 100mg OR 300mg tablets		Paediatric solution e.g. ½ strength Darrows (200ml or 500ml) solution AND neonatalyte 200ml solution	
Atropine 0.5mg OR 1mg ampoule		Prednisone 5 mg tablets OR Prednisolone tablets	
Calcium Gluconate 10% 10ml ampoule		Promethazine 25mg/2ml 2ml ampoule OR Promethazine 25mg/1ml ampoule	
Naloxone 0.4mg/1ml 1 ml ampoule**		Short acting sublingual nitrates e.g. glyceryl trinitrate SL OR isosorbide dinitrate sublingual, 5 mg tablets	
50% dextrose (20ml ampoule or 50ml bag) OR 10% dextrose 1L solution		Salbutamol 0.5% 20ml nebulising solution OR 2.5mg/2.5ml OR 5mg/2.5ml Unit dose vial for nebulisation OR Salbutamol 100 mcg MDI OR Fenoterol 1.25mg/2ml Unit dose vial for nebulisation	
Furosemide 20mg OR 10mg/2ml ampoule		Sodium chloride 0.9% 1L solution	
Hydrocortisone 100mg/ml OR 200mg/2ml vial		Streptokinase 1.5 MIU injection**	
Ipratropium 0.25mg/2ml OR 0.5mg/2ml Unit dose vial for nebulization		Thiamine 100mg/ml 10ml vial	
Total			
Total maximum possible score (sum of all scores minus those marked NA)			
Score (Total ÷ Total maximum possible score)			

Annexure 83: Checklist for element 113 - health care waste is managed appropriately in the medicine/dispensary room

Use the checklist below to check whether health care waste is managed appropriately

Scoring – in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant

Item	**Score**
General waste is disposed of separately in a black/beige/white or transparent plastic bag	
Pharmaceutical waste is stored separately in a container or box for removal to the disposing health facility	
Total	
Score (Total ÷ 2)	

Annexure 84: Checklist for element 104 - Basic surgical supplies (consumables) are available

Use the checklist below to check availability of medical and dressing supplies

Scoring – in column for score mark as follows:

Check – available stock in storage room

Y (Yes) = available; **N** (No) = not available; **NA** (not applicable) = if the facility uses consumables for older HB models, AEDs and for the section named "Only applicable if the facility have a permanent doctor"

SURGICAL SUPPLIES			
Item	**Score**	**Item**	**Score**
Intravenous administration set 20 drops/ml		Gloves exam n/sterile large /box	
Intravenous administration set paeds 60 drops/ml		Gloves exam n/sterile medium /box	
Blade stitch cutter sterile/pack		Gloves exam n/sterile small /box	
Urinary (Foley's) catheter silicone/latex 10f		Gloves surg sterile sz6 OR6.5 OR small/box	
Urinary (Foley's) catheter silicone/latex 12f		Gloves surg sterile sz 7OR 7.5 OR medium/box	
Urinary (Foley's) catheter silicone/latex 14f		Gloves surg sterile sz 8 OR large/box	
Urinary (Foley's) catheter silicone/latex 18f		Intravenous cannula 18ggreen/box	
Urine drainage bag		Intravenous cannula 20g pink/box	
Simple face mask for oxygen for adults		Intravenous cannula 22g blue/box	
Reservoir mask for oxygen for adults		Intravenous cannula 24g yellow/box	
Nasal cannula (prongs) for adults		Needles: 18 (pink) OR 20 (yellow)/box	
Simple face mask for oxygen, paediatric		Needles: 21 (green)/box	
Reservoir mask for oxygen for paediatric		Needles: 23 (blue)/box OR 22 (black)/box	
Simple face mask for oxygen for adults		* Syringes 3-part 2ml/box	
Reservoir mask for oxygen for adults		* Syringes 3-part 5ml/box	
Face mask for nebuliser OR face mask with nebuliser chamber for adult		* Syringes 3-part 10 or 20ml/box	
Face mask for nebuliser OR face mask with nebuliser chamber for paediatric		Insulin syringe with needle/box	
Nasogastric tubes: 400mm - 600mm fg 8		Suture chromic g0/0 or g1/0 1/2 75cm	
Nasogastric tubes: 800 - 1200mm fg10 or 12		Suture nylon g2/0 or g3/0 3/8 45cm	
Disposable aprons		Suture nylon g4/0 3/8 45cm	
Eye patches (disposable)			
Disposable razors/ disposable shaving set			
Vaginal Cusco speculum (disposable)			
Only applicable if the facility uses older HB model			
Haemolysis applicator sticks		HB chamber glass-grooved	
HB meter clip		HB cover glass-plain	

Only applicable if facility uses an Automatic External Defibrillator (AED)					
Replacement pads for AED - adult			Replacement pads for AED – paediatric		
Only applicable if facilities have a permanent doctor					
Disposable Amnihook			Dental syringe and needle for LA		
Ultrasound gel medium viscosity					
Sub-total 1 for surgical supplies			**Sub-total 2 for surgical supplies**		
Sub-total 1 Maximum score (sum of all scores minus those NA)			**Sub-total 2 Maximum score (sum of all scores minus those NA)**		
DRESSINGS SUPPLIES					
Item	**Pack size**	**Score**	**Item**	**Pack size**	**Score**
Plaster roll	1		Sanitary towels maternity /pack	12	
Bandage crepe	1		Stockinette 100mm OR150mm/roll	1	
Gauze paraffin 100x100 /box	1		Adhesive micro-porous surgical tape 24/25mm or 48/50mm	1	
Gauze swabs plain n/s 100x100x8ply/pack	100		70% isopropyl alcohol prep pads 24x30 1ply OR 2 ply /box	200	
Basic disposable dressing pack(should contain a minimum of: cotton-wool balls, swabs, 2 forceps, disposable drape)	1		Gauze abs grade 1 burn /pack		
Cotton wool balls 1g 500`s	1				
Sub-total 1 for dressing supplies			**Sub-total 2 for dressing supplies**		
Total for surgical and dressing supplies					
Total maximum score for surgical supplies (sum of all scores minus those marked NA) and dressing supplies					
Score (Totals ÷ Total maximum)					

***** Syringe three part consists of the barrel, the plunger and the rubber piston

Annexure 85: Checklist for element 117 - Required functional diagnostic equipment and concurrent consumables for point of care testing are available

Use the checklist below to check the availability of laboratory equipment and consumables in the various areas where they are used

Scoring – in column for score mark as follows:

Y (Yes) = available; **N** (No) = not available; **NA** (not applicable) = only for malaria rapid strips – in areas where malaria is not prevalent, malaria rapid strips to be marked NA

Item	Score
Laboratory equipment and consumables	
Hb meter	
Blood glucometer	
Spare batteries for blood glucometer	
Lancets	
Blood glucose strips	
Urine dipsticks	
Urine specimen jar OR flask	
Malaria rapid test (where applicable in facilities in KZN, GP, MP and LP)	
Rapid HIV test	
Rh 'D' (Rhesus factor) test	
Total score for all (Total score laboratory equipment + consumables + stationery)	
Total maximum possible score (sum of all scores minus those marked NA)	
Percentage (Total score ÷ Total maximum possible score) x 100	**%**

Annexure 86: Checklist for element 118 - Required specimen collection materials and stationery are available

Use the checklist below to check whether specimen collection materials and stationery are available

Scoring – in column for score mark as follows:

Y (Yes) = available; **N** (No) = not available; **NA** (Not applicable) = as indicated

Item	**Score**
Vacutainer tube: Blue Top (Sodium Citrate)	
Vacutainer tube: Red OR Yellow Top (SST)	
Vacutainer tube: Yellow Top (SST-Paeds)	
Vacutainer tube: Grey Top (Sodium Fluoride)	
Vacutainer tube: White Top (PPT)	
Microtainer tube: Purple Top (EDTA)	
Microtainer tube: Purple Top (EDTA Paeds)	
Sterile specimen jars	
Swabs with transport medium (Score NA if there is not a permanent doctor)	
Sterile Tubes (without additive) for MCS (Microscopy, culture and sensitivity) (Score NA if there is not a permanent doctor)	
Venipuncture needles (Green OR Black)	
Specimen Plastic Bags	
Pap smear collection materials	
Liquid - based Cytology (LBC) vials (NA if facility uses traditional pap smear method)	
Combi - brush (NA if facility uses traditional pap smear method)	
Cervex – brush (NA if facility uses traditional pap smear method)	
Fixative (NA if facility uses liquid based cytology method)	
Wooden spatula (NA if facility uses liquid based cytology method)	
Slide holder OR brown envelope (NA if facility uses liquid based cytology method)	
Microscope slides (NA if facility uses liquid based cytology method)	
Early Infant diagnosis (EID) collection material	
DBS PCR Kit OR EDTA Microtainer tube (where PCR is performed at the laboratory)	
NHLS stationery	
Request forms	
N1 -PHC Request Form	
N2- Cytology Request Form	
N3 - PHC Order Book Material for specimen collection	
N4 - PHC Facility Specimen Register	
SMS printer	
Thermal paper roll (NA only if facility has real-time access to Labtrak)	
Total Score	
Percentage (Score ÷ 21) x 100	

Illustration of NHL specimen collection materials

See the correct specimen collection material as per specimen key next to each test

Specimen collection material	KEY
Vacutainer tube: Red Top	**R**
Vacutainer tube: Blue Top (Sodium Citrate)	BL
Vacutainer tube: Yellow Top (SST) and (SST-Paeds)	Y
Vacutainer tube: Grey Top (Sodium Fluoride)	G
Vacutainer tube: White Top (PPT)	W
Vacutainer tube: Purple Top (EDTA) and Microtaoner (EDTA Paeds)	P
Sterile specimen jars	SJ
Dried blood spot	DBS

Test	Specimen collection material	Test	Specimen collection material
CHEMICAL PATHOLOGY			
ALP (Alkaline Phosphatase)	**Y**	Phenytoin	**Y**
ALT(Alanine Transaminase)	**Y**	Pleural effusion Protein	**R**
Amylase/Lipase	**Y**	Potassium (serum)	**Y**
Calcium (serum)	**Y**	Prostate-Specific Ag (PSA)	**Y**
Cholesterol	**Y**	Sodium (serum)	**Y**
Creatinine (eGFR) (serum)	**Y**	Total Bilirubin	**Y**
CRP (C-reactive protein)	**Y**	Triglycerides	**Y**
Folate (serum)	**P**	TSH (Thyroid-stimulating hormone)	**Y**
FT4 (Free Throxine 4)	**Y**	Uric Acid (serum)	**Y**
Gamma GT (GGT) (Serum)	**Y**	Urine albumin:creatinine ratio	**SJ**
Glucose	**G**	Urine protein:creatinine ratio	**SJ**
HbA1c (Glycated Haemoglobin)	**Y**	Vitamin B12	**Y**
LDL-Cholesterol (LDL-C)	**Y**		
Haematology		**Microbiology**	
Differential count	**P**	CRAG (Cryptococcal Antigen test)	**Y**
Full Blood Count (FBC)	**P**	Hepatitis A IgM	**Y**
Haemoglobin	**P**	Hepatitis B Surface Ab	**Y**
INR (International Normalized Ratio)	**B**	HIV Elisa (discordant rapids)	**Y**
Platelets	**P**	Stool parasites	**SJ**
Red Cell Antibody screen (Coomb's Test)	**P**	Syphilis Serology	**Y**
White Blood Cell (WBC)	**P**	MCS (Microscopy, culture band sensitivity)	
HIV viral load		**TB testing**	
HIV Viral Load	**W/P**	Xpert MTB/RIF	**SJ**
HIV DNA PCR		TB Smear microscopy	**SJ**
HIV DNA PCR	**DBS/P**	TB Culture	**SJ**
HIV CD4 Count		TB Drug Susceptibility	**SJ**
CD4 Count	**P**	TB Line Probe Assay (Hain MTBDR)	**SJ**
Blood grouping			
ABO (Blood grouping)	**Y**		
Rhesus Factor (Rh)	**Y**		

Annexure 87: Checklist for element 119 - Specimens are collected, packed, stored and prepared for transportation according to the primary health care Laboratory Handbook

Use the checklist below to check whether specimens are handled according to the PHC Laboratory Handbook

Scoring – in column for score mark as follows:

Check – three samples from each of the groups of specimens (A to C) as listed in Table 1 and check whether they comply with the guidelines provided

Y (Yes) = handled correctly; **N** (No) = not handled correctly; **NA** (not applicable) = NA if the facility does not have the specific group of specimen listed in Table 1 in storage.

Table 1: Grouping of specimens

Group A	Group B	Group C
Blood Pleural effusion Sputum Stool Urine	Pap smear	MCS (Microscopy, culture band sensitivity)

Item	Group A			Group B			Group C		
	Score sample 1	Score sample 2	Score sample 3	Score sample 1	Score sample 2	Score sample 3	Score sample 1	Score sample 2	Score sample 3
General									
Specimens are clearly labeled									
Each laboratory request form is correctly completed									
There is at least one functional wall mounted thermometer in area where lab specimens are stored for courier collection									
The temperature of the storage area for lab specimens is recorded daily									
Group A specimens									
Samples are kept away from direct sunlight									

Where the room temperature exceeds 25°C, samples are stored in the fridge (at +- 5°C)									
Length of storage does not exceed 24 hours, stored at room temperature (+- 20-25°C)									
Group B specimens									
Stored at room temperature									
Stored inside a slide carrier (envelope)									
Group C specimens									
Samples placed into the transport medium provided (where appropriate)									
Samples kept away from direct sunlight									
Where room temperature exceeds 25°C, samples are stored in the fridge (+- 5°C)									
Length of storage does not exceed 24 hours, stored at room temperature (+-20-25°C)									
Score									
Maximum possible score (sum of all scores minus those marked NA)									
Total score for all samples									
Total maximum possible score (sum of all sample scores minus those marked NA)									
Percentage (Total score ÷ Total maximum possible score) x 100									**%**

Annexure 88: Checklist for element 120 - Laboratory results are received from the laboratory within the specified turnaround times

Use the checklist below to check whether the turnaround times for laboratory results are in line with specifications

Scoring – in column for score mark as follows:

Check – register for sending and receiving laboratory results, check three records

Y (Yes) = results received within specified turnaround time; **N** (No) = results NOT received within specified turnaround time; **NA** (not applicable) = if the specific result (listed under point 1 to 9) is not in the record

No	Item	Turnaround time	Score record 1	Score record 2	Score record 3
1	All blood results except those listed in number 2 and 3	24 hours			
2	Blood results: Cholesterol, CRP (C-reactive protein), FT4 (Free Throxine 4), HbA1c (Glycated Haemoglobin), Phenytoin, lipase, PSA (Prostate specific hormone), Red Cell Folate, Triglycerides, TSH (Thyroidstimulating hormone), Vitamin B12, CD4 Count, RPR (Rapid Plasma Reagin test for syphilis), Hepatitis A, B or C	24-48 hours			
3	Blood results: HIV PCR for infants	48-120 hours			
4	Blood results: Viral load	48-120 hours			
5	Pap smear	Variable depending on result (4-6 weeks)			
6	MCS (Microscopy, culture band sensitivity)	24-72 hours			
7	Sputum: TB	5 days-6 weeks			
9	Sputum: Xpert MTB/RIF	40 hours			
9	Stool	24 - 72 hours			
10	Urine	24 – 72 hours			
	Total				
	Total maximum possible score (sum of all samples checked minus those marked NA)				
	Percentage (Total score ÷ Total maximum possible score) x 100				**%**

Annexure 89: Checklist for element 124: Staff appointed is in line with determined requirements

Use the checklist below to check whether the staff appointed at the facility is appointed according to the determined requirement

Scoring - in column for score mark as follows:

Y (Yes) = compliant, **N** (No) = not compliant, **NA** (not applicable) = if staff is not required according to determined need

Category of staff	**Score**
Medical practitioner	
Pharmacy	
Pharmacist	
Pharmacist assistant – basic	
Pharmacist assistant – post basic	
Nurses	
Clinical Nurse Practitioners	
Advanced midwife	
Professional nurses	
Enrolled nurses	
Enrolled nursing assistants	
Oral health	
Dentist	
Dental assistant	
Dental therapist	
Oral hygienist	
Allied health professionals	
Occupational therapists	
Physiotherapists	
Speech and hearing therapists	
Social workers	
Nutritionists/dietitians	
Optometrists	
Psychologist	
Management	
Facility manager	
Support Staff	
Administrative officers	
Cleaners (general assistants)	
Grounds men	
Security officers	
Total	
Total maximum possible score (sum of all scores minus those marked NA)	
Score (Totals ÷ Total maximum possible scores)	

Annexure 90: Example of a work allocation schedule for staff

Date from		Date to		
Name and surname of staff member	**Designation**	**Service area**	**Date**	**Signature**

Annexure 91: Annual leave schedule (first 6 months)

Facility name: _____

Year: _____

Month	January				February				March				April				May				June			
Name and surname of staff member	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4
Example: Mr Xy																								
Example: Ms DB																								
Example: Mr TT																								

ANNUAL LEAVE SCHEDULE (Second 6 months)

Facility name: _____

Year: _____

Month	July				August				September				October				November				December			
Name and surname of staff member	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4
Example: Mr FF																								
Example: Ms DG																								
Example: Mr DT																								

Annexure 92: Checklist for element 130: All healthcare workers have current registration with relevant professional bodies

Use the checklist below to check whether staff appointed at the facility is registered with relevant professional bodies

Scoring - in column for score mark as follows:
Y (Yes) = have current registration, **N** (No) = do not have current registration, **NA** (not applicable) = if category of staff in not appointed at the facility

Category of staff	Score	Category of staff	Score
Nurses			
Clinical Nurse Practitioners		Enrolled nurses	
Professional nurses		Nursing assistants	
Medical officers			
Medical Officer – full time		Medical officer- sessional - private GP	
Medical officer- sessional			
Oral health			
Dentists – full time		Dental therapist	
Dentist – sessional		Dental assistant	
Dentist – sessional – private		Oral hygienist	
Pharmacy			
Pharmacist		Pharmacist assistants	
Allied health professionals			
Nutritionist/Dietician		Social workers	
Physiotherapist		Optometrist	
Occupational therapist		Speech and hearing therapist	
Psychologist			
Totals			
Total maximum possible scores (sum of total scores minus the ones marked NA)			
Score (Totals ÷ Total maximum possible score)			

Annexure 93: Checklist for element 131: Performance Management guidelines are adhered to

Use the checklist below to check whether Performance Management guidelines are adhered to

Scoring –in column for score mark as follows:

Check – randomly select three files for review

Y (Yes) = completed; **N** (No) = not completed; **NA** (Not applicable) = if the facility has less than three staff members or the staff member is working less than a year

Item	Score
Performance management agreement signed for the current financial year	
Key performance areas and activities aligned with the facility's operational plan	
Personal Development Plan completed	
Evaluation is conducted six monthly	
Annual assessment report for previous financial year completed	
Total	
Total maximum possible score (sum of all scores minus those marked NA)	
Score (Total ÷ Total maximum possible score)	

Annexure 94: Example of a staff satisfaction survey

Rate the below questions as follows:

Disagree =1, Slightly disagree = 2, Slightly agree = 3, Agree = 4, Strongly agree = 5

ID	Question	Score				
1	**Staff Satisfaction Survey**	**1**	**2**	**3**	**4**	**5**
1.1	**Personal profile**					
1.1.1	Facility name:					
1.1.2	Occupational class:					
1.1.3	Occupational band:					
1.1.4	Race:					
1.1.5	Gender:					
1.1.6	Age group:					
1.1.7	Years of service:					
1.1.8	Language:					
1.2	**Survey questions (score ranges from 0 to 5)**					
1.2.1	**Direction/strategy/integration**					
1.2.1.1	I am clear on what the Department of Health's strategies and goals are and my role in supporting their attainment					
1.2.1.2	The Department of Health's strategies and goals directly supports those of the National Department of Health					
1.2.1.3	I am aware of the initiatives to create better integration of policies and coordination across units					
1.2.1.4	The implementation of integration policies will optimise use of resources and enhance efficiencies					
1.2.1.5	Management actively supports the integration initiatives					
1.2.2	**Morale**					
1.2.2.1	I feel valued as an employee					
1.2.2.2	I enjoy being a part of this organisation					
1.2.2.3	Employees have a good balance between work and personal life					
1.2.2.4	Morale is high across the organisation					
1.2.2.5	Employees speak highly about this organisation					
1.2.3	**Workload**					
1.2.3.1	There is enough staff employed to meet work demands in the organisation					
1.2.3.2	I am given enough time to do my job well					
1.2.3.3	Sufficient time is available to work on agreed high priority activities					
1.2.4	**Wellbeing and security**					
1.2.4.1	I feel in control and on top of things at work					
1.2.4.2	I feel emotionally well at work					
1.2.4.3	I am able to keep my job stress at an acceptable level					
1.2.4.4	I feel safe in my work environment					
1.2.5	**Job satisfaction**					
1.2.5.1	My work gives me a feeling of personal accomplishment					
1.2.5.2	I like the kind of work I do					
1.2.5.3	Overall I am satisfied with my job					
1.2.6	**Organisation commitment**					
1.2.6.1	I feel a sense of loyalty and commitment to the organisation					
1.2.6.2	I am proud to tell people that I work at DoH					
1.2.6.3	I feel emotionally attached to the organisation					
1.2.6.4	I am willing to put in extra effort for the organisation					

1.2.7	**Diversity**					
1.2.7.1	Diversity among staff is valued					
1.2.7.2	Sexual harassment is prevented and discouraged at the organisation					
1.2.7.3	Discrimination is prevented and discouraged at the organisation					
1.2.7.4	Bullying and abusive behaviours are prevented and discouraged at the organisation					
1.2.7.5	There is equal opportunity for all staff in the organisation					
1.2.7.6	The organisation has effective procedures for handling employee grievances					
1.2.7.7	Management provides support to staff in reporting any discrimination or harassment					
1.2.8	**Change and innovation**					
1.2.8.1	Change is handled well in the organisation					
1.2.8.2	The way the organisation is run has improved over the last year					
1.2.8.3	The organisation is innovative					
1.2.8.4	The organisation is good at learning from its mistakes and successes					
1.2.9	**Comments**					
1.2.9.1	Please provide any suggestions or recommendations you have to improve performance across the organisation					
1.2.10	**Client orientation and quality of service**					
1.2.10.1	We understand the specific needs of our clients (people we provide service to)					
1.2.10.2	We are focused on delivering high-quality and timeous services to our clients					
1.2.10.3	We have sufficient facilities equipment and supplies to deliver quality service					
1.2.10.4	Our services meet our clients' needs					
1.2.10.5	Department of Health's services are accessible to the community.					
1.2.10.6	Department of Health's services are well known and appreciated in the community.					
1.2.11	**Employee/management relations**					
1.2.11.1	Management sets high standards of excellence					
1.2.11.2	Management creates an environment where employees are enabled to perform their jobs well					
1.2.11.3	Management values the role that unions play in the organisation					
1.2.11.4	Management and unions engage in constructive conflict resolution					
1.2.11.5	Management encourages collaboration across the organisation					
1.2.11.6	Management treats employees fairly					
1.2.12	**Respect**					
1.2.12.1	I feel my input is valued by my peers					
1.2.12.2	Knowledge and information sharing is a group norm across the organisation					
1.2.12.3	Employees consult each other when they need support					
1.2.12.4	Individuals appreciate the personal contributions of their peers					
1.2.12.5	When disagreements occur they are addressed promptly in order to resolve them					
1.2.13	**Role clarity**					
1.2.13.1	The organisation’s goals and objectives are clear to me					
1.2.13.2	Employees have a shared understanding of what the organisation is supposed to do					
1.2.13.3	Roles and responsibilities within the group are understood					
1.2.13.4	Clear reporting structures have been established					
1.2.13.5	Employees at this organisation have the right skill sets to perform their job functions					
1.2.13.6	My role has a clearly defined performance expectation					

1.2.14	**Performance/reward systems**					
1.2.14.1	People are involved in setting their own performance goals					
1.2.14.2	People are recognised for achieving their goals					
1.2.14.3	People are rewarded for the quality of their work					
1.2.14.4	There is a clear link between performance and rewards					
1.2.14.5	Management gives feedback that is specific enough to be used for improving their performance					
1.2.14.6	When people do not perform up to their potential action is taken to help them improve and grow					
1.2.14.7	People are rewarded for team efforts not only individual performance					
1.2.15	**Communication**					
1.2.15.1	I receive the information I need to perform my job well					
1.2.15.2	When I need help I can ask others in my work group for suggestions or ideas					
1.2.15.3	Interpersonal communication and relationships contribute to organisational performance					
1.2.15.4	Our face-to-face meetings are productive					
1.2.15.5	The organisation uses effective methods to communicate important information					
1.2.16	**Career development**					
1.2.16.1	When a position needs to be filled in this organisation the best person for the job is the one who gets it					
1.2.16.2	The organisation continuously invests in developing the skills of its employees					
1.2.16.3	The organisation has effective training and education programmes to assist people to do their jobs effectively					
1.2.16.4	My responsibilities include challenging goals that encourage personal growth					
1.2.16.5	The organisation actively retains scarce talent required for efficient quality care					
1.2.17	**Decision-making/management structures**					
1.2.17.1	The structure of the organisation supports cooperation between functions and departments					
1.2.17.2	I believe that the organisation manages its finances responsibly					
1.2.17.3	The organisation supports the implementation of Batho Pele principles to ensure that poor people are not further disadvantaged by the system					
1.2.17.4	There are clear policies and procedures for how work is to be done					
SUB TOTAL SCORE (add the scores in each column)						
TOTAL (add subtotal scores						
AVERAGE PERCENTAGE (total/(109*5)						**%**

Annexure 95: Checklist for element 138: SOP for management of occupational health and safety incidents is available

Use the checklist below to check whether the topics as listed is covered in the SOP

Scoring –in column for score mark as follows:

Check – the content of the SOP

Y (Yes) = compliant; **N** (No) = not compliant

Item	Score
Standardised form to be completed to report an occupational health and safety incident	
Process for submitting completed forms	
Format for register to record occupational health and safety incidents	
Analysis of incidents to establish trends	
Total	
Score ÷ 4	

Annexure 96: Occupational Health and Safety Register

OCCUPATIONAL HEALTH AND SAFETY REGISTER

NAME OF FACILITY: _____

FINACIAL YEAR: _____

Date of Injury	Time of Injury	Name and surname of employee	Persal number of employee	Summary of description of incident	Summary of investigation conducted	Outcome of investigation	Recommendations to prevent reoccurrence	Date recom-mendations implemented	Official forms submitted to district (Yes/No)
APRIL									
MAY									
JUNE									
JULY									
AUGUST									

SEPTEMBER									
OCTOBER									
NOVEMBER									
DECEMBER									
JANUARY									
FEBRUARY									
MARCH									

Verified at end of financial year by: Name and Surname_____ Signature: _____Date:_____

Annexure 97: Checklist for element 141: Occupational Health and Safety incidents are managed and recorded in a register

Use the checklist below to check whether the Occupational Health and Safety register is completed

Scoring –in column for score mark as follows:

Check – the register for entries of incidents six month prior to the status determinations

Y (Yes) = completed; **N** (No) = not completed; **NA** (Not applicable) = if the facility had no occupational health and safety incidents

Item	Score
Summary of description of incident	
Summary of investigation conducted	
Outcome of investigation	
Recommendation/s	
Date recommendations implemented	
Personnel who experience needle stick injuries received post-exposure prophylaxis	
Total	
Total maximum possible score (sum of all scores minus those marked NA)	
Score (Total ÷ Total maximum possible score)	

Annexure 98: Expenditure report

NAME OF FACILITY: _____ **FINANCIAL YEAR**:_____

SUBJECT: EXPENDITURE REPORT

MAIN ITEM	COMPENSATION OF EMPLOYEE	GOODS AND SERVICES	MACHINERY & EQUIPMENT	PROV & LOCAL GOVERNMENT	HOUSEHOLDS	TOTAL
BUDGET	R 5,301,000	R6,491,000	R 1,251,000		R 259,000	R 13,302,000
APRIL'15	R 345,650	R 79,427				R 425,107
MAY'15	R 300,845	R 1,161,304				R 1,462,149
JUNE'15	R 399,783	R 464,126				R 863,909
JULY'15						R -
AUGUST'15						R -
SEPTEMBER'15						R -
OCTOBER'15						R -
NOVEMBER'15						R -
DECEMBER'15						R -
JANUARY'16						R -
FEBRUARY'16						R -
MARCH'16						R -
ACTUAL	R 1,046,308	R 1,704,857	R -	R -	R -	R 2,751,165
VARIANCE	R 4,254,692	R 4,786,143	R 1,251,000	R -	R 259,000	R 10,550,165
% SPENT	20	26				21
PROJECTION	R 1,395,077	R 2,273,143	R -	R -	R -	R 3,668,220

EXPECTED MONTHLY EXPENDITURE

COMPENSATION OF EMPLOYEES	R 44,175,000
GOODS AND SERVICES	R540,917
MACHINERY & EQUIPMENT	
TOTAL	R 982,667

Annexure 99: Checklist for element 149 - Disinfectant, cleaning materials and equipment are available

Use the checklist below to check whether the disinfectant, cleaning materials and equipment are available

Scoring – in column for score mark as follows:

Y (Yes) = available; **N** (No) = not available; **NA** = Not applicable e.g.:

- Mop for exterior areas for facilities that do not have exterior areas to clean.
- Polish, stripper and floor polisher in facilities where the floor surface does not require polishing.

Disinfectant and cleaning Material	**Score**
High-level disinfection for medical equipment (e.g sodium perborate powder OR phthalaldehyde)	
Chlorine compounds (e.g Biocide D or Clorox)	
Alcohol based agent (70%-90%)	
Detergents – neutral pH	
Wet polymer (floor polish)	
Protective polymer (strippers)	
All cleaning materials clearly labelled	
Materials Safety Data Sheets for all cleaning products	
Cleaning equipment	**Score**
Two-way bucket system for mopping floors (bucket for clean water and bucket for dirty water) OR Janitor trolley	
Colour labelled mop – Red for toilets and bathrooms	
Colour labelled mop – Blue for clinical areas and non-clinical service areas	
Mop labelled for cleaning exterior areas	
Green bucket and cloths for bathroom and consulting room basins	
Red bucket and cloths for toilet	
White cloths for kitchen	
Blue bucket and cloths for clinical areas and non-clinical service areas	
Spray bottle for disinfectant solution	
Window cleaning squeegee	
Mop sweeper or soft-platform broom	
Floor polisher	
Total score	
Total maximum possible score (sum of total scores minus those marked NA)	
Percentage (Total score ÷ Total maximum possible score) x 100	

Annexure 100: Regulations for material safety data sheets

Hazardous Chemical Substances Regulations, 1995

The Minister of Labour has under section 43 of the Occupational Health and Safety Act, 1993 (Act No. 85 of 1993), after consultation with the Advisory Council for Occupational Health and Safety, made the regulations in the Schedule.

9A (1) Subject to section 10(3) of the Act, every person who manufactures, imports, sells or supplies any hazardous chemical substance for use at work, shall, as far as is reasonably practicable, provide the person receiving such substance, free of charge, with a material safety data sheet in the form of Annexure 1, containing all the information as contemplated in either ISO 1 1014 or ANSIZ400.1.1993 with regard to-

(a) product and company identification;
(b) composition/information on ingredients;
(c) hazards identification;
(d) first-aid measures;
(e) fire-fighting measures;
(f) accidental release measures;
(g) handling and storage;
(h) exposure control/personal protection;
(i) physical and chemical properties;
(j) stability and reactivity;
(k) toxicological information;
(l) ecological information;
(m) disposal considerations;
(n) transport information;
(o) regulatory information; and
(p) other information:

Provided that, where it is not reasonably practicable to provide a material safety data sheet, the manufacturer, importer, seller or supplier shall supply the receiver of any hazardous chemical substance with sufficient information to enable the user to take the necessary measures as regards the protection of health and safety.

(2) Every employer who uses any hazardous chemical substance at work, shall be in possession of a copy of Annexure 8 or a copy of sufficient information, as contemplated in subregulation (1).

(3) Every employer shall make Annexure 8 or sufficient information, as contemplated in sub regulation (1), available at the request of any interested or affected person.

ANNEXURE 8

Material safety data sheet

MATERIAL SAFETY DATA SHEET	No: Date issued: Page of
COMPANY DETAILS	
Name: Address: Tel:	Emergency telephone no.: Telex: Fax:
1) Product and Company Identification: **(Page 1 may be used as an emergency safety data sheet)**	
Trade name : Chemical family : Chemical name: Synonyms:	Chemical abstract no. : NIOSH no.: Hazchem code: UN no.:
2) Composition	
Hazardous components: EEC classification: R Phrases:	
3) Hazards Identification	
Main hazard: Flammability: Chemical hazard: Biological hazard: Reproductive hazard: Eye effects: eyes: Health effects - skin: Health effects - ingestion: Health effects - inhalation: Carcinogenicity: Mutagenicity: Neurotoxicity:	
4) First-aid Measures	
Product in eye: Product on skin: Product ingested: Product inhaled:	
5) Fire-fighting Measures	
Extinguishing media: Special hazards: Protective clothing:	
6) Accidental Release Measures	
Personal precautions: Environmental precautions: Small spills: Large spills:	
7) Handling and Storage	
Suitable material:	

Handling/storage precautions:
8) Exposure Control/Personal Protection
Occupational exposure limits: Engineering control measures: Personal protection - respiratory: Personal protection - hand: Personal protection - eye: Personal protection - skin: Other protection:
9) Physical and Chemical Properties
Appearance: Odour: pH: Boiling point: Melting point: Flash point: Flammability: Auto flammability: Explosive properties: Oxidizing properties: Vapour pressure: Density: Solubility - water: Solubility - solvent: Solubility - coefficient
10) Stability and Reactivity
Conditions to avoid: Incompatible materials: Hazardous decomposition products:
11) Toxicological Information
Acute toxicity: Skin and eye contact: Chronic toxicity: Carcinogenicity: Mutagenicity: Neurotoxicity: Reproductive hazards:
12) Ecological Information
Aquatic toxicity - fish: Aquatic toxicity - daphnia Aquatic toxicity - algae Biodegradability: Bio-accumulation: Mobility: German wgk:
13) Disposal Considerations
Disposal methods: Disposal of packaging:
14) Transport Information
UN no. Substance indentity no. ADR/RID class:

ADR/RID item no. ADR/RID hazard identity no.: IMDG - shipping name: MDG - class: IMDG - packaging group: IMDG - marine pollutant: IMDG - EMS no. IMDG - WAG tabel no.: IATA - shipping name: IATA - class: IATA - subsidiary risk(s): ADNR - class: UK - description: UK - emergency action class: UK - classification: Tremcard no.:
15) Regulatory Information.

EEC hazard classification: Risk phases: Safety phases: National legislation:	

16) Other Information

Annexure 101: Checklist for element 150: All work completed is signed by cleaners and verified by manager or delegated staff member

Use the checklist below to check whether all work is signed by cleaners and verified by manager or delegated staff member

Scoring - in column for score mark as follows:

Y (Yes) = signed off, **N** (No) = not signed off, **NA** (not applicable) = if there are fewer areas in the clinic

Area	**Score area 1**		**Score area 2**	
	Signed by cleaner	Signed by supervisor	Signed by cleaner	Signed by supervisor
Consultation rooms (randomly select 2 rooms)				
Vital rooms				
Waiting area				
Public toilets (randomly select 2toilets)				
Staff toilets (randomly select 2 toilets)				
Staff room(s)				
Total				
Total maximum possible score (sum of all scores minus those marked NA)				
Score (Total ÷ Total maximum possible score)				

Annexure 102: Checklist for element 151 – All service areas are clean

Use the checklist below to check whether the various service areas are clean

Scoring – in column for score mark as follows:

Check – randomly select two service areas as indicated in the column for the score

Y (Yes) = compliant; **N** (No) = not compliant; **NA** (not applicable) = if there are fewer areas in the clinic than listed

Area and measures	**Score**	**Score**
CONSULTING ROOMS:	**Consulting room 1**	**Consulting room 2**
Windows clean		
Window sills clean		
Floor is clean		
Wall skirting are free of dust		
The countertops are clean		
The door handles are clean		
Mirrors are clean		
Walls are clean		
Bins are not overflowing		
Bins are clean		
The areas are odour-free		
All areas free of cobwebs		
Score for consultation rooms		
Maximum possible score for consultation rooms (sum of all scores minus NA)		
Percentage for consulting rooms (Score ÷ Total maximum possible score) x100	%	
VITAL SIGNS ROOMS:	**Vital signs room 1**	**Vital signs room 2**
Windows clean		
Window sills clean		
Floor is clean		
Wall skirting are free of dust		
The countertops are clean		
The door handles are clean		
Mirrors are clean		
Walls are clean		

Bins are not overflowing		
Bins are clean		
The areas are odour-free		
All areas free of cobwebs		
Score for vital signs rooms		
Maximum possible score for vital rooms (sum of all scores minus NA)		
Percentage for vital signs rooms (Score ÷ Total maximum possible score) x 100		%
WAITING AREAS:	**Waiting area 1**	**Waiting area 2**
Windows clean		
Window sills clean		
Floor is clean		
Wall skirting are free of dust		
The countertops are clean		
The door handles are clean		
Walls are clean		
Bins are not over flowing		
Bins are clean		
The areas are odour-free		
All areas free of cobwebs		
Score for waiting areas		
Maximum possible score for waiting areas (sum of all scores minus NA)		
Percentage for waiting rooms (Total score ÷ Total maximum possible score) x 100		%

Annexure 103: Checklist for element 152 – Hand hygiene and sanitary facilities are available

Use the checklist below to check whether there is running water, toilet paper, liquid hand wash soap and disposable hand paper towels

Scoring –in column for score mark as follows:

Check – randomly select two toilets, two consulting rooms and two vital signs room to review

Y (Yes) = available; **N** (No) = not available; **NA** (not applicable) if the facility has fewer areas than listed for review or (*) During drought episodes taps can be closed, facility must then have alcohol-based hand rub available.

Item	Area 1	Area 2
Toilet	**Toilet 1**	**Toilet 2**
Functional hand wash basin		
Taps functional with running water (*)		
Toilet paper		
Liquid hand wash soap		
Disposable hand paper towels		
Consultation room	**Consultation room 1**	**Consultation room 2**
Functional hand wash basin		
Taps functional with running water (*)		
Liquid hand wash soap		
Alcohol based hand rub		
Disposable hand paper towels		
Vital signs room	**Vital signs room 1**	**Vital signs room 2**
Functional hand wash basin		
Taps functional with running water (*)		
Liquid hand wash soap		
Alcohol based hand rub		
Disposable hand paper towels		
Total		
Total maximum possible score (sum of all scores minus those marked NA)		
Score (Total ÷ Total maximum possible score)		

Annexure 104: Checklist for element 153: SOP for managing general and health care risk waste is available

Use the checklist below to verify that the SOP describes the topics as listed

Scoring - In column for score mark as follows:

Y (Yes) = compliant, **N** (No) = not compliant.

Item	**Score**
Segregation containers	
Handling of segregated waste	
Storage of segregated waste	
Collection	
Disposal of waste	
Total	
Score (Total ÷ 5)	

Annexure 105: Checklist for element 154 - Health care waste is managed appropriately

Use the checklist below to check whether health risk care waste is managed appropriately

Scoring - in column for score mark as follows:

Y (Yes) = available/with lid and appropriately lined; **N** (No) = not available or no lid or not appropriately lined; **NA** (not applicable) = if the facility has fewer than listed areas

Item	Score				
	Staff Toilet	**Public Toilet**	**Clinical area 1**	**Clinical area 2**	**Waiting area**
Sanitary disposal bins with functional lids OR health care risk waste box					
* Sanitary disposal bins/boxes lined with appropriate colour plastic bags					
Sanitary disposal bins/boxes are clean and not overflowing					
Health care risk waste disposal bins with functional lids OR health care risk waste box					
Health care risk waste disposal bins/boxes lined with red colour plastic bags					
Health care risk waste disposal bins/boxes contain only health care waste					
Health care risk waste disposal bins/boxes are not overflowing					
Anatomical waste (Red bucket with sealed lid) applicable where male medical circumcisions or deliveries are done					
Bins available for general waste					
Bins for general waste are lined with black, white, transparent or beige coloured bags					
Total					
Total maximum possible score (sum of all scores minus those marked NA)					
Score (Total ÷ Total maximum possible score)					

* If disposable boxes for sanitary waste is used where gel granules in the bottom of the box treat the waste, no bag is required, and facility can score “Y”

Annexure 106: Checklist for element 155 – Storage are for healthcare waste is appropriate

Use the checklist below to check whether storage areas for healthcare waste is appropriate

Scoring - in column for score mark as follows:

Y (Yes) = comply; **N** (No) = do not comply

General waste storage area	**Score**
General waste is stored in a designated area	
General waste is stored in appropriate containers which are neatly packed or stacked	
General waste is not burned or buried in the health establishment premises but collected for disposal at a designated area/landfill	
Health care risk waste storage area	**Score**
Health care risk waste is stored in an access-controlled area	
Health care waste storage area is clean and free from rodents	
Health care storage area is well ventilated	
Health care risk waste containers are not stored directly on the floor, i.e. it is stored on shelves or pallets or wheelie bins	
Area has access to water to hose the area	
Area has adequate drainage for the water (must be connected to a municipal sewerage system)	
Central storage area is enclosed and protected from natural elements (rain, wind and sun)	
Area is marked with international biohazard symbol	
Total	
Score (Total ÷ 11)	

Annexure 107: Checklist for element 156 – All toilets are clean, intact and functional

Use the checklist below to check whether the toilets are functional

Scoring – in column for score mark as follows:

Check – randomly select three toilets to review

Y (Yes) = intact; **N** (No) = not intact; **NA** (not applicable) = if the facility has fewer than three toilets or has no urinals

Item	Score Toilet 1	Score Toilet 2	Score Toilet 3
Cleanliness of toilets			
Windows clean			
Window sills clean			
Floor is clean			
Basins are clean			
Walls are clean			
Toilets/urinals are clean			
Sanitary bins clean and not overflowing			
The areas are odour-free			
All areas free of cobwebs			
Intact and functional			
The toilet bowl seat and cover/squat pan is intact			
The toilet bowl is stain free			
The toilet flush/sensor flush is functional			
The toilet cistern cover is complete and in place			
The urinals are intact and functional			
The urinal/flush sensor is functional			
Total			
Total maximum possible score (sum of all 3 toilets (minus those marked NA)			
Percentage (Total score ÷ Total maximum possible score) x 100			

Annexure 108: Checklist for element 157 - Exterior of the facility and the grounds are clean and well maintained

Use the checklist below to check whether the exterior of the facility is aesthetically pleasing and clean

Scoring – in column for score mark as follows:

Check – observe the general exterior environment of the facility

Y (Yes) = compliant; **N** (No) = not compliant; **NA** (not applicable) = if the facility's structural make-up does not allow for gardens e.g. in a multi-storey building in a city, at least one prompt must be scored, e.g. "There is no dirt and litter around facility premises"

Prompts	**Score**
The facility's premises are clean (e.g. free from dirt and litter)	
Exterior walls of the facility are clean	
Verandas are clean	
Grass is cut	
Paving is free of weeds	
Flower beds are well kept and free of weeds	
Total score	
Total maximum possible score (sum of all scores minus NA)	
Percentage (Total score ÷ Total maximum possible score) x 100	**%**

Annexure 109: Schedule for pest control

PEST CONTROL SCHEDULE

Name of facility: _____

Year:_____

Key: Pest control scheduled to take place

ITEM	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Pest control schedule												
Date completed												
Comments (where applicable)												
Facility manager's signature												

Annexure 110: Checklist for element 163: Safety and security SOP is available

Use the checklist below to verify that the SOP describes the topics as listed

Scoring – in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant

Item	**Score**
High risk areas and the specific security needs for these areas	
Access control within the facility	
Reporting of security incidents (format for register for security breaches)	
Training of personnel on the management of alarms (where applicable)	
Provision of guarding services	
Patrolling of the health facility	
Equipment for security personnel	
Documentation of response time for security breaches/incidents	
Total	
Score (Total ÷ 8)	

Annexure 111: Checklist for element 166 - There is a standard security guard room OR the facility has an alarm system linked to armed response

Use the checklist below to check whether facility security adheres to standard guidelines

Scoring – in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant; **NA** (not applicable) = if the facility's structural make-up does not allow for its own security guard room e.g. in a multi-storey building in a city or at very small facilities. Security services should, however, still be available therefore measures listed under equipment and stationery must be scored.

Item	Score
Does the facility have an alarm system linked to armed response (if Yes, checklist for security guardroom and security equipment must not be assessed. If No, assess checklist for security guardroom and security equipment)	
Security guard room	
Kitchenette – sink with cupboard underneath	
Table	
Chair	
Functioning lights	
Security equipment for security officer(s) and accompanying stationery	
Baton	
Handcuffs OR Cable ties	
Incident book	
Metal detector	
Telephone OR two-way radio OR dedicated cellphone	
Total score	
Total maximum possible score (sum of all scores minus NA)	
Percentage (Total score ÷ Total maximum possible score) x 100	**%**

Annexure 112 : Checklist for element 168: Security services rendered according to contract

Use the checklist below to check whether the security services are rendered according to contract

Scoring – in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant; **NA** (not applicable) = for whichever option is not in operation at the clinic

Item	Score
If armed response is available	
Response time indicated in register for security breaches	
If there were breaches did they respond in time?	
If security guards are available	
Security guards wear uniform	
Security guards have received training	
Duty patrol register updated	
There is an access control system in the facility	
Total	
Total maximum possible score (sum of all scores minus those marked NA)	
Score (Total ÷ Total maximum possible score)	

Annexure 113: Register for security breaches

Name of facility: _____

Year: _____

Date of breach	Name of surname of staff managing the breach	Name and surname of staff and or patients involved in the breach (where applicable)	Short description of the breach	Short description of how the breach was managed	Actions taken to prevent reoccurrence	Signature of staff managing the breach
January						
February						
March						
April						
May						
June						
July						
August						

September						
October						
November						
December						

Annexure 114: Checklist for element 170: Security breaches are managed and recorded in a register

Use the checklist below to check whether security breaches are managed and recorded in a register

Scoring – in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant; NA = if the facility had no security breaches in the past three months. Zero reporting must be done in such cases.

Item	Score
A designated person monitors the service level agreement for security services	
Security breaches are recorded in a register	
Remedial actions to address security breaches identified are implemented	
Total	
Total maximum possible score (sum of all scores minus those marked NA)	
Score (Total ÷ Total maximum possible score)	

Annexure 115: Checklist for element 171 – Functional firefighting equipment is available

Use the checklist below to check whether firefighting equipment is available

Scoring – in column for score mark as follows:

Y (Yes) = available and intact; **N** (No) = not available and intact; **NA** (not applicable) = for fire hose if the facility has less than 250 m^2 floor area OR the facility has no water supply

Item	Score
Fire extinguishers	
Fire hoses and reels unless it is a single-storey building of less than 250 m^2 in floor area OR the facility has no water supply	
Two 9 kg or equivalent fire extinguishers where the facility has no water supply	
Firefighting equipment is maintained according to schedule	
Total score	
Percentage (Total ÷ 4) x 100	**%**

Annexure 116: Control sheet for inspection of firefighting equipment

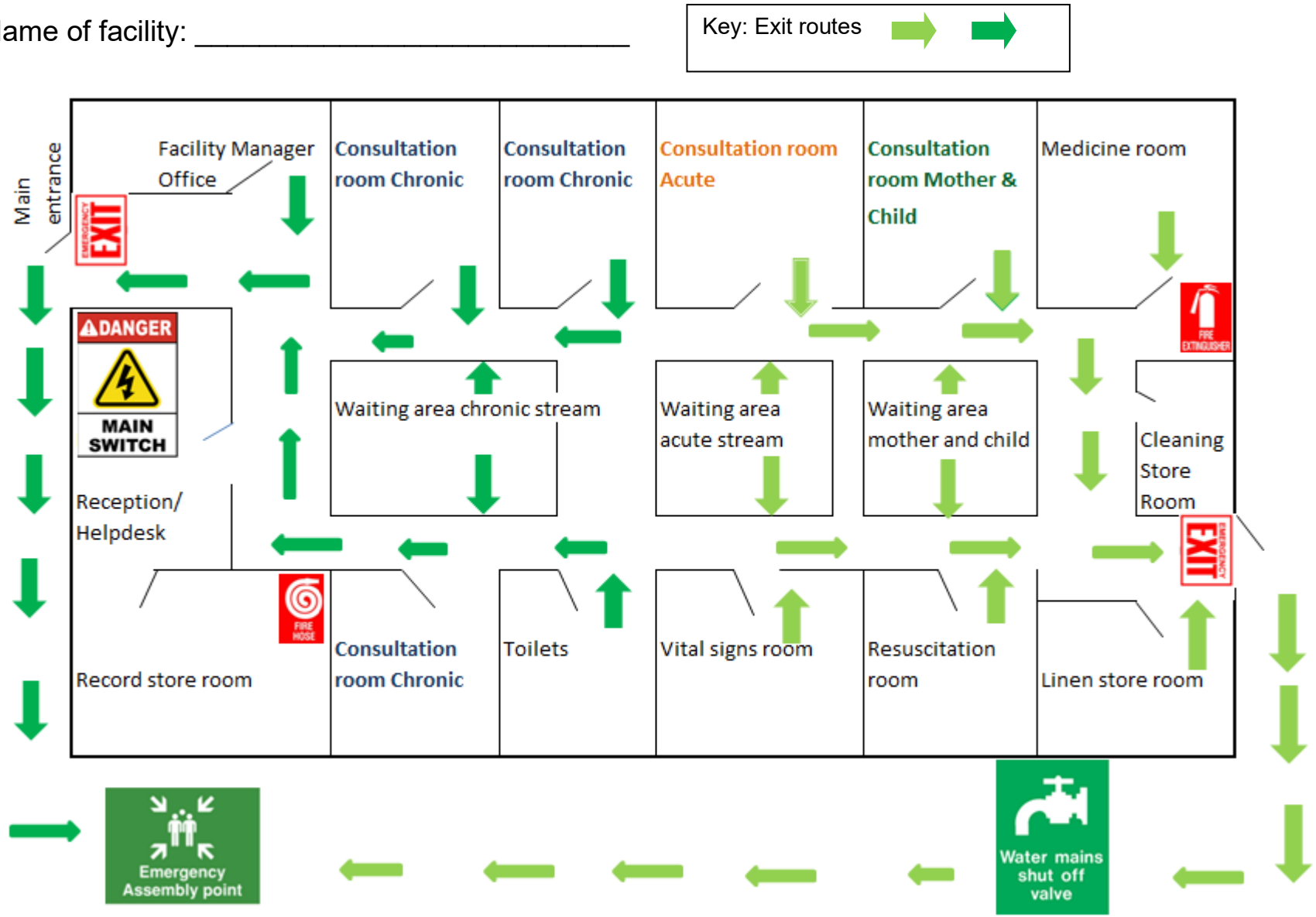
Facility name: _____

Date inspected: _____

Type of firefighting equipment	Location	Date of last service	Date of next service	Condition of equipment

Annexure 117: Evacuation plan

Name of facility: _____



Annexure 118: Evacuation drill report

Date of evacuation drill	Staff member responsible for arranging and conducting drill	Findings of evacuation drill (short falls)	Corrective action taken	Date of repeating drill to establish if shortfalls were corrected

Annexure 119: Checklist for element 181 - Clinic space accommodates all services and staff

Use the checklist below to check whether internal and external areas offer sufficient space for task performance

Scoring – in column for score mark as follows:

Check – whether the following areas are present and sufficient

Y (Yes) = available; **N** (No) = not available; **NA** (not applicable) = for small facilities that cannot accommodate all recommended areas

Item	Score
INTERIOR SPACE	
General	
Main waiting area	
Help desk/Reception/patient registration	
Toilets	
Clinical Service Areas	
Sub-waiting area	
Vitals area /room	
Consulting room	
Counseling room	
Emergency/resuscitation room	
Health Support services (Allied health)	
Treatment room	
Support /administration areas	
Multipurpose meeting room	
Facility manager office	
Staff tea room with kitchenette	
Medicine store room /dispensary/Pharmacy	
Shelves available	
Medicine collection kiosk (CCMDD)	
Surgical stores store-room	
Lockable cleaning material store room OR cupboard	
Laundry	
Dirty utility room	
Linen room OR cupboard	
Exterior space	
Parking spaces	
a. Staff	
b. Disabled	
c. Ambulance	
Waste storage room	
a. Domestic/general waste area	
b. Medical/bio-hazardous waste area	
Garden store room	
Drying area (for mops, etc.)	
Total score	
Total maximum possible score (sum of all scores minus NA)	
Percentage (Total score ÷ Total maximum possible score) x 100	

Annexure 120: Checklist for element 182: All clinical areas have adequate natural (windows) or functional mechanical ventilation (ceiling fans/air conditioner)

Use the checklist below to check whether the various areas have adequate ventilation

Scoring – in column for score mark as follows:

Check – randomly select the number of areas to review as indicated in the column for scores
Y (Yes) = available; **N** (No) = not available; **NA** (not applicable) = if the facility has fewer than the listed areas

Area	**Score**	
WAITING AREA:	**Score Waiting time area 1**	**Score Waiting time area 2**
Have adequate ventilation		
VITAL SIGNS ROOMS:	**Score Vital signs room 1**	**Score Vital signs room 2**
Have adequate ventilation		
CONSULTATION ROOM	**Score Consultation room 1**	**Score Consultation room 2**
Have adequate ventilation		
Total score		
Total maximum possible score (sum of all scores minus NA)		
Percentage (Total score ÷ Total maximum possible score) x 100		

Annexure 121: Checklist for element 183: There is access for people with wheelchairs

Use the checklist below to check accessibility for users in wheelchairs

Scoring – in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant

Item	Score
Terrain must be compacted and smooth from gate to main entrance	
At least one main entrance has a ramp to allow access for persons in wheelchairs unless the entrance to the facility has no incline	
Ramp at one main entrance has handrails unless the entrance to the facility has no incline	
Elbow taps in toilet with access for persons in wheelchairs	
At least one toilet has access for persons in wheelchairs	
In the toilet/s with access for persons in wheelchair, door handles are at the height of a wheelchair s	
In the toilet/s with access for persons in wheelchairs handrails are installed	
Total score	
Percentage (Total score ÷7) x 100	**%**

Annexure 122: Checklist for element 185 - The building/s is maintained

Use the checklist below to check whether the various internal and external areas are in good condition

Scoring –in column for score mark as follows:

Check – randomly select the number of areas to review as indicated in the column for scores

Y (Yes) = available; **N** (No) = not available; **NA** (not applicable) = if the facility has fewer than the listed areas or measure is not applicable to the specific facility because of the structural make-up of the facility e.g. in a multi storey building in a city

Area and measures	**Scores Building exteriors**	
EXTERIOR OF BUILDING(S)		
Walls – paint in good condition		
Roof intact		
Gutters		
a. Intact		
b. Paint in good condition		
Doors and gates		
a. Working condition		
b. Handles working		
c. Open and close		
Lights		
a. Present		
b. Functional		
Paving is intact		
Total		
Total maximum possible score (sum of all scores minus those marked NA)		
Score (Total ÷ Total maximum possible score)		
INTERIOR OF BUILDING(S)		
WAITING AREAS	**Score Waiting area**	**Score Waiting area**
Walls – paint in good condition		
Ceiling		
a. Paint in good condition		
b. Intact		
Lights		

a. Present		
b. Functional		
Total		
Total maximum possible score (sum of all scores minus those marked NA)		
Score (Total ÷ Total maximum possible score)		
TOILETS	**Score ablution 1**	**Score ablution 2**
Wall-mounted paper towel dispenser(s)		
Wall-mounted hand soap dispenser(s)		
Wall tiles in good condition		
Walls – paint in good condition		
Ceiling		
a. Paint in good condition		
b. Intact		
Lights		
a. Present		
b. Functional		
Windows		
a. Window panes intact (glass not broken)		
b. Handles working		
c. Windows open and close		
Doors		
a. Intact		
b. Handles working		
c. Open and close		
Hand wash basins		
a. Intact		
b. Taps functional (with running water)		
c. Not blocked		
Floor intact		
Total		
Total maximum possible score (sum of all scores minus those marked NA)		
Score (Total ÷ Total maximum possible score)		
CONSULTATION ROOMS	**Score Consultation room 1**	**Score Consultation room 2**
Wall-mounted paper towel dispenser(s)		

Wall-mounted hand soap dispenser(s)		
Walls – paint in good condition		
Floor in good condition		
Ceiling		
a. Paint in good condition		
b. Intact		
Lights		
a. Present		
b. Functional		
Windows		
a. Window panes intact (glass not broken)		
b. Handles working		
c. Windows open and close		
d. Window covering (curtains/blinds) clean and intact (blinds)		
Doors		
a. Intact		
b. Handles working		
c. Open and close		
Hand wash basins		
a. Intact		
b. Taps functional (with running water)		
c. Not blocked		
Total		
Total maximum possible score (sum of all scores minus those marked NA)		
Score (Total ÷ Total maximum possible score)		
VITAL SIGNS ROOMS:	**Score Vital signs room 1**	**Score Vital signs room 2**
Wall-mounted paper towel dispenser(s)		
Wall-mounted hand soap dispenser(s)		
Walls – paint in good condition		
Floor intact		
Ceiling		
a. Paint in good condition (not peeling/faded)		
b. Intact (not broken)		
Lights		
a. Present		
b. Functional		

Windows		
a. Glass not broken		
b. Handles working		
d. Windows open and close		
Doors		
a, Intact		
b. Handles working		
c. Open and close		
Hand wash basins		
a. Intact		
b. Taps functional		
c. Not blocked		
Total		
Total maximum possible score (sum of all scores minus those marked NA)		
Score (Total ÷ Total maximum possible score)		

AREA	**Score**	**Maximum possible score**
Exterior of building(s)		
Interior of building(s)		
Waiting areas		
Ablution facilities		
Vital signs rooms		
Consultation rooms		
Total		
Total maximum possible score (sum of all scores minus those marked NA)		
Score (Total ÷ Total maximum possible score)		

Annexure 123: Example of a record to track maintenance work

Maintenance/ works order number	Date maintenance requested	Name and surname of staff member that requested the maintenance	Short description of maintenance requested	Notes on dates on which follow-ups were made	Date maintenance carried out and finalised

Annexure 124: Checklist for element 186 - Building is compliant with safety regulations

Use the checklist below to check whether the building is compliant with safety regulations

Scoring – in column for score mark as follows:

Y (Yes) = available; **N** (No) = not available

Item	Score
Fire compliance certificates	
Electrical compliance certificates	
All emergency exits are kept free of obstacles	
Entrance is free from any obstruction or hazards	
Emergency vehicle entrance is free from any obstruction or hazards	
Total	
Score (Total ÷ 4)	

Annexure 125: Checklist for element 187 - Furniture is available and intact in service areas

Use the checklist below to check whether facility service areas are equipped with sufficient functional furniture

Scoring – in column for score mark as follows:

Check – randomly select the areas to review as indicated in the column for scores

Y (Yes) = available and intact; **N** (No) = not available or not intact; **NA** (not applicable) = where the facility has fewer than the listed areas

Item	Score	Score
Waiting areas	**Waiting area 1**	**Waiting area 2**
Seating		
a. Adequate seating for all patients		
b. Chairs / benches intact		
Notice boards available		
Consulting rooms	**Consultation room 1**	**Consultation room 2**
Desk		
a. Available		
b. Intact (including the drawers)		
Chair (clinician)		
a. Available		
b. Intact		
At least 1 chair (patient)		
a. Available		
b. Intact		
Tilting examination couch		
a. Available		
b. Intact		
Bedside footstool		
a. Available		
b. Intact		
Wall-mounted or portable anglepoise-style examination lamp		
a. Available		
b. Intact		
Lockable medicine cupboards		
a. Available		
b. Intact		

Dressing trolley (at bedside for examination equipment)		
a. Available		
b. Intact (including the drawers)		
Total score for waiting areas and consulting rooms		
Total maximum possible score (sum of all waiting areas and consulting rooms minus those marked NA)		
Percentage (Total score ÷ Total maximum possible score) x 100		

Annexure 126: Checklist for element 188 - Essential equipment is available and functional in consulting areas

Use the checklist below to check whether essential equipment is available and functional in consultation/vital signs and child health rooms

Scoring – in column for score mark as follows:

Check – randomly select the number of areas to review as indicated in the scoring columns

Y (Yes) = available and functional; **N** (No) = not available or not functional; **NA** (not applicable) = if the facility has fewer than the listed areas

Item	Score Consul-tation room 1	Score Consul-tation room 2	Score Vitals room	Score Child health rooms
CONSULTATION ROOMS				
Stethoscope				
Non-invasive Baumanometer (wall mounted/ portable)				
Adult, paediatric and large cuffs (3) for Baumanometer				
Diagnostic sets including ophthalmic pieces (wall mounted or portable)				
Patella hammer				
Tuning fork (only required in one consultation room)				
Tape measure				
Vaginal cusco speculum				
Clinical thermometers				
Score for consultation rooms				
Maximum possible score (sum of all scores minus those marked NA)				
Percentage (Score ÷ Maximum possible score) x 100				**%**
VITAL SIGNS ROOM (Note if facility is too small to have a vital signs room, check for equipment in consultation rooms)				
Non-invasive electronic Baumanometer (wall mounted/ portable)				
Adult, paediatric and large cuffs (3) for Baumanometer				
Blood glucometer				
Peak flow meter				
Adult clinical scale up to 150 kg				
Stethoscope				

HB meter				
Clinical thermometer				
Height measure				
Tape measure				
Bin (general waste)				
Urine specimen jars				
Score for vital signs rooms				
Maximum possible score (sum of all scores minus those marked NA)				
Percentage (Score ÷ Maximum possible score) x 100				**%**
CHILD HEALTH ROOM				
Baby scale				
Bassinet				
Stethoscope				
Blood glucometer				
Non-invasive Baumanometer (wall mounted/ portable)				
Paediatric cuff for Baumanometer				
Diagnostic sets including ophthalmic pieces (wall mounted or portable)				
Patella hammer				
Tape measure				
Clinical thermometers				
Score for child health room				
Maximum possible score (sum of all scores minus those marked NA)				
Percentage (Score ÷ Maximum possible score) x 100				**%**

AREA	**Score**	**Maximum possible score**
Consultation rooms		
Vital signs rooms		
Child health rooms		
Total score/Total maximum possible score		
Percentage (Total score ÷ Total maximum possible score) x 100		**%**

Annexure 127: Example of a maintenance schedule for equipment

MAINTENANCE SCHEDULE FOR EQUIPMENT

Name of facility: _____

Equipment/details of service	**Date equipment procured**	**Frequency of maintenance**	**1st service scheduled**	**2nd service scheduled**	**3rd service scheduled**	**4th service scheduled**	**5th service d scheduled**	**6th service scheduled**
Automatic External Defibrillator (AED) OR ECG monitor and defibrillator						**Serial number**		
Schedule of Service(example)	*1 Apr 2017	Annual	1 Apr 2018	1 Apr 2019	1 Apr 2020	1 Apr 2021	1 Apr 2022	1 Apr 2023
Date serviced	[redacted]							
Company or health technology technician that serviced the equipment								
Facility manager's Name & surname that signed off the service								
Signature of facility manager to confirm that the service was conducted								
Pulse oximeter with adult & paediatric probes						**Serial number**		
Schedule of Service								
Date serviced	[redacted]							
Company or health technology technician that serviced the equipment								
Facility manager's Name & surname that signed off the service								
Signature of facility manager to confirm that								

the service was conducted							
Non invasive electronic blood pressure monitoring device including paediatric, adult & large adult cuff sizes (recalibration)					**Serial number**		
Schedule of Service							
Date serviced							
Company or health technology technician that serviced the equipment							
Facility manager's Name & surname that signed off the service							
Signature of facility manager to confirm that the service was conducted							
Scales (recalibration)					**Serial number**		
Schedule of Service							
Date serviced							
Company or health technology technician that serviced the equipment							
Facility manager's Name & surname that signed off the service							
Signature of facility manager to confirm that the service was conducted							

* If the facility has more than one of the equipment listed, add lines to include all equipment with its serial number.

Add all the equipment that must be serviced on the schedule

Annexure 128: Checklist for element 192: Resuscitation room is equipped with functional basic equipment for resuscitation

Use the checklist below to check whether the emergency/resuscitation room complies with measures for functional basic equipment

Scoring – in column for score mark as follows:

Check – room where resuscitation is performed

Y (Yes) = available and functional; **N** (No) = not available or not functional

Item	Score
Emergency trolley with lockable medicine drawer and accessories	
Examination couch/2-part obstetric delivery bed	
Wall or ceiling mounted anglepoise-style examination lamp	
Nebuliser OR face mask with nebuliser chamber for adult and paediatric	
Functional electric powered OR manual suction devices and suction catheters	
Drip stand	
Dressing trolley	
Cardiac arrest board	
Bin (general waste)	
Thermal (space) blanket	
Gloves exam n/sterile gloves: small, medium and large at least one pair of each size	
Gloves surgical sterile latex: 6 OR 6.5, 7 OR 7.5 and 8, at least one pair of each size	
Protective face shields OR Goggles	
Disposable plastic aprons	
Disposable non-sterile face masks	
Resuscitation algorithms	
Resuscitation documentation register	
Wall-mounted liquid hand soap dispenser	
Wall-mounted hand paper dispenser	
Total score	
Percentage (Total ÷ 21) x 100	**%**

Annexure 129: Checklist for element 193 - Emergency trolley is restored daily or after each used

Use the checklist below to check whether the emergency trolley is sufficiently stocked with unexpired medication

Scoring – in column for score mark as follows:

Check – whether the equipment and medication area available on the emergency trolley (or on other surfaces in the resuscitation room); and also ***check expiry date of medication. Mark expired medication as "N"***

Y (Yes) = available and functional or within expiry; **N** (No) = not available or not functional or expired; **NA** = as indicated

NOTE:

- Equipment is divided into equipment for facilities that have a permanently appointed doctor and those who do not have a permanently appointed doctor. Facilities that do not have a permanently appointed doctor must mark **NA** at the section indicated for equipment for facilities with a permanently appointed doctor.
- Facility can only score **NA** for AED/ECG if the facility has a signed letter by the Provincial Head of Health indicating that the facility is exempted from this measure.

Item	Score
EQUIPMENT FOR ALL FACILITIES (with and without a permanently appointed doctor)	
Water-soluble lubricant/lubricating jelly	
Oropharyngeal airways (Guedel) size 00	
Oropharyngeal airways (Guedel) size 0	
Oropharyngeal airways (Guedel) size 1	
Oropharyngeal airways (Guedel) size 2	
Oropharyngeal airways (Guedel) size 3	
Oropharyngeal airways (Guedel) size 4	
Oropharyngeal airways (Guedel) size 5	
Magill's forceps for adults	
Magill's forceps for paediatric	
Manual bag valve mask/ manual resuscitator OR self-inflating bag with compatible masks for adults	
Manual bag valve mask/ manual resuscitator OR self-inflating bag with compatible masks for paediatric	
Simple face mask for oxygen for adults	
Reservoir mask for oxygen for adults	
Nasal cannula (prongs) for adults	
Simple face mask for oxygen, paediatric	
Reservoir mask for oxygen for paediatric	
Nasal cannula (prongs) for paediatric	
Face mask for nebuliser OR face mask with nebuliser chamber for adult	
Face mask for nebuliser OR face mask with nebuliser chamber for paediatric	

Automatic External Defibrillator (AED) OR ECG monitor and defibrillator	
Defibrillator pads for AED OR Electrodes for ECG monitor and defibrillator	
Conductive gel (NA if the facility uses a AED)	
Intravenous cannula 18g green and appropriate strapping	
Intravenous cannula 20g pink and appropriate strapping	
Intravenous cannula 22g blue and appropriate strapping	
Intravenous cannula 24g yellow and appropriate strapping	
Syringes 3-part: 2ml	
Syringes 3-part: 5ml	
Syringes 3-part: 10ml OR 20ml	
Syringes: insulin syringes	
Needles: 18 (pink) OR 20 (yellow)	
Needles: 21 (green)	
Needles: 23 (blue) OR 22 (black)	
Suture chromic g0/0 or g1/0 1/2 75cm	
Suture nylon g2/0 or g3/0 3/8 45cm	
Suture nylon g4/0 3/8 45cm	
Suction catheters: sizes 8F	
Suction catheters: sizes 10F	
Suction catheters: sizes 12F	
Suction catheters: sizes 14F	
Sharps container	
Admin set 20 drops/ml 1.8m /pack	
Admin set paeds 60 drops/ml 1.8m /pack	
Stethoscope	
Haemoglobin meter	
Blood glucometer with testing strips and spare batteries	
Diagnostic set and batteries including ophthalmic pieces (wall mounted or portable)	
Rescue scissors (to cut clothing)	
Paediatric Broselow tape OR Pawper tape	
Wound care (gauze, bandages, cotton wools, plasters, alcohol swabs and antiseptic solutions)	
Urinary (Foley's) catheters: 8f	
Urinary (Foley's) catheters: 10f	
Urinary (Foley's) catheters: 12f	
Urinary (Foley's) catheters: 14f	
Urinary (Foley's) catheters: 16f	
Urinary (Foley's) catheters: 18f	
Urinary bag specified in the surgical supply list	
Nasogastric tubes: 400mm - 600mm fg 8	
Nasogastric tubes: 800 - 1200mm fg10 or 12	
Medication/vacolitre stickers	

Present individually or in combined multifunctional diagnostic monitoring set	
Pulse oximeter with adult & paediatric probes	
Non invasive electronic blood pressure monitoring device including paediatric, adult& large adult cuff sizes	
Clinical thermometer (in ^{0}C, non-mercury)	
EQUIPMENT FOR FACILITIES WITH A PERMANENT APPOINTED DOCTOR	
Laryngoscope handle with functional batteries	
Adult curved blades for laryngoscope size 2	
Adult curved blades for laryngoscope size 3	
Adult curved blades for laryngoscope size 4	
Paediatric laryngoscope handle	
Paediatric straight blades for laryngoscope size 00	
Paediatric straight blades for laryngoscope size 0	
Paediatric straight blades for laryngoscope size 1	
Spare bulbs for laryngoscope (NA if the laryngoscope has a built in bulb)	
Spare batteries for laryngoscope handle	
Endotracheal tubes – uncuffed size 2.5mm	
Endotracheal tubes –uncuffed size 3.0mm	
Endotracheal tubes – uncuffed size 3.5mm	
Endotracheal tubes – uncuffed size 4mm	
Endotracheal tubes –uncuffed size 4.5mm	
Endotracheal tubes – cuffed size 3.0mm	
Endotracheal tubes – cuffed size 4.0mm	
Endotracheal tubes – cuffed size 5.0mm	
Endotracheal tubes – cuffed size 6.0mm	
Endotracheal tubes – cuffed size 7.0mm	
Endotracheal tubes – cuffed size 8.0mm	
Tape to hold tie endotracheal tube in place	
Adult-size introducer, intubating stylet or bougie for endotracheal tubes	
Paediatric size introducer, intubating stylet or bougie for endotracheal tubes	
Laryngeal masks (supraglottic airways): adult (size 3 OR 4 Or 5)	
Emergency medicines (also check expiry dates) – *APPLICABLE TO ALL FACILITIES*	
Activated Charcoal	
Adrenaline 1mg/ml (Epinephrine)1ml ampoule	
Amlodipine 5mg OR 10mg tablets	
Aspirin 100mg OR 300mg tablets	
Atropine 0.5mg OR 1mg ampoule	
Calcium gluconate 10% 10ml ampoule	
Furosemide 20mg OR 10mg/2ml ampoule	
Hydrocortisone 100mg/ml OR 200mg/2ml vial	
Insulin, short acting (stored in the medicine fridge) vial	

Ipratropium 0.25mg/2ml OR 0.5mg/2ml unit dose vial for nebulisation	
Lidocaine/Lignocaine IM 1% OR 2% 20ml vial	
Magnesium sulphate 50%, 1g/2ml ampoule (minimum of 14 ampoules required for one treatment course)	
Midazolam (1mg/ml 5 ml ampoule OR 5mg/ml 3ml ampoule) OR Diazepam 5mg/ml 2ml ampoule	
Nifedipine 5mg/10mg capsules	
Prednisone 5 mg tablets	
Promethazine 25mg/2mlampoule OR Promethazine 25mg/1ml	
Short-acting sublingual nitrates e.g. glyceryl trinitrate SL OR isosorbide dinitrate sublingual, 5mg tablets	
Salbutamol 0.5% 20ml nebulising solution OR 2.5mg/2.5ml OR 5mg/2.5ml Unit dose vial for nebulisation OR Salbutamol 100 mcg MDI OR Fenoterol 1.25mg/2ml Unit dose vial for nebulisation"	
Thiamine 100mg/ml 10ml vial	
Water for injection	
IV Solutions	
50% dextrose (20ml ampoule or 50ml bag) OR 10% dextrose 1L solution	
Pediatric solutions e.g. ½ strength Darrows (200ml or 500ml) solution AND neonatalyte200ml solution	
Sodium Chloride 0.9% solution 1L solution	
Total	
Total maximum possible score (sum of all scores minus those marked NA)	
Score (Total ÷ Total maximum possible score)	

Annexure 130: Checklist for element 194 – There is an emergency sterile obstetric delivery pack

Use the checklist below to check whether there are sterile emergency packs available.

Scoring – in column for score mark as follows:

Y (Yes) = available; **N** (No) = not available

Note: sterile packs must be labelled with the contents of the pack

Item	Quantity	Total score
NON-NEGOTIABLE		
Stitch scissor	1	
Episiotomy scissor	1	
Cord scissor	1	
Dissecting forceps non-toothed (plain)	1	
Dissecting forceps toothed	1	
Artery forceps, straight, long	2	
Needle holder	1	
Small bowl	2	
Kidney dishes OR receivers (big)	2	
EXTRAS (not part of sterilised pack)		
Basin	1	
Stainless-steel round bowl, large	1	
Sterile green towels	4	
Sterile gown		
Disposable apron	2	
Gauzes	5	
Vaginal tampons	1	
Sanitary towels	2	
Round cotton wool balls	1 pack	
Umbilical cord clamps	2	
Total score		
Percentage (Total score ÷ 18) x 100		**%**

Annexure 131: Checklist for element 195 – There is a sterile pack for minor surgery

Use the checklist below to check whether equipment for minor surgery is available

Scoring – in column for score mark as follows:

Y (Yes) = available and functional; **N** (No) = not available or not functional

Note: sterile packs for minor surgery must be labelled indicating the contents of the pack

Item	Quantity	Score
MINOR STITCH / SUTURING TRAY		
Small stitch tray	1	
Stitch scissor	1	
Toothed forceps	1	
Non-toothed forceps	1	
Bard-Parker surgical blade handle to fit accompanying blades (blades do not form part of sterilised pack but must be available)	1	
Mosquito, straight	2	
Mosquito, curved	2	
Artery forceps, straight	2	
Artery forceps, curved	2	
Needle holder	1	
Swab holder	1	
Total score		
Percentage (Total score ÷ 11) x 100		**%**

Annexure 132: Checklist for oxygen supply

Checklist for oxygen supply			
Facility:		**Date from:**	**Date to:**
Day of the week	**Pressure gauge reading**	**Date checked**	**Signature**
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

Annexure 133: Checklist for element 199- Up to date asset register available

Use the checklist below to check whether the asset register is up to date

Scoring – in column for score mark as follows:

Y (Yes) = present; **N** (No) = not present

Item	Item 1	Item 2	Item 3
Randomly select three items from the asset register and verify that each is present in the facility			
Randomly select three items from the facility and verify that each is present in the asset register			
Total score			
Percentage (Total score ÷ 6) x 100			**%**

Annexure 134: Example of an asset disposal form

Asset disposal form

This form is to be completed if any equipment/furniture within the facility is to be disposed of. This form, once completed, must be sent to Supply Chain Management.

Region: _____ Facility: _____

Department: _____ Date: _____

LIST OF EQUIPMENT/FURNITURE TO BE DISPOSED						
	Asset number	**Location**	**Description**	**Purchase date**	**Original cost**	**Disposal value**
1						
2						
3						
4						
5						
6						
7						
8						

REASON FOR DISPOSAL:

_____

_____

_____

_____

____

METHOD OF DISPOSAL (please tick)

SCRAPPED ☐

AUCTION ☐

DONATED ☐

Authorised by: _____Date: _____

Annexure 135: Checklist for element 203: Facility has a functional back-up electricity supply when needed

Use the checklist below to check whether the back-up electricity supply is functional and available in the areas as indicated

Scoring - in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant; **NA** (Not Applicable) = if the facility has fewer areas as indicated for review

Area	Score
Back-up electricity supply is maintained in accordance with the manufacturer's instructions	
Back-up electricity supply is tested for functionality in accordance with the manufacturer's instructions	
Lights and plugs in the resuscitation room is connected to the back-up electricity supply	
Medicine/dispensary room connected to the back-up electricity supply (At a minimum the vaccine and medicine fridge must be connected to the back-up supply)	
Total	
Score (Total ÷4)	

Annexure 136: Schedule for meetings

MEETING SCHEDULE

Facility name: _____

Month: _____

Year: _____

Weekday	Date	Week 1	Date	Week 2	Date	Week 3	Date	Week 4
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								

Annexure 137: Template for agenda

FACILITY NAME: _____

AGENDA FOR: _____

DATE: _____

VENUE: _____

AGENDA POINTS:
1. Opening and welcome
2. Attendance and apologies
3. Finalisation of the agenda
4. Adoption of the previous meeting minutes
5. Matters arising from the previous meeting's minutes
6. Standing items
7. Additional matters
8. Date of next meeting
9. Closure

Annexure 138: Template for attendance register for meetings

FACILITY NAME: _____

ATTENDANCE REGISTER FOR: _____

DATE: _____

VENUE: _____

Name and surname	Rank	Contact number	Organisation / section	Signature

Annexure 139: Checklist for element 217: Staff members demonstrate that incoming policies/guidelines/SOPs/ notices have been read and are understood by appending their signatures on such policies/guidelines/SOPs/ notices

Staff should sign for all incoming policies/guidelines/SOP/notices. This checklist lists the clinical guidelines relating to the National priority health conditions

Scoring – in column for score mark as follows:

Check – whether staff has signed to acknowledge that they have taken note and understood the content of the guidelines

Y (Yes) = signed; **N** (No) = did not sign; **NA** (not applicable) = if the facility does not provide the service

Item	Score
ICSM compliant package of clinical guidelines	
Adult Primary Care guide (APC) – 2019 or Practical Approach to Care Kit (PACK), 2019	
Integrated Management of Childhood Illness Chart Booklet, 2019	
Standard Treatment Guidelines and Essential Medicines List for Primary Health Care, 2020	
Standard Treatment Guidelines and Essential Medicines List for Hospital Level, Adults, 2019	
Standard Treatment Guidelines and Essential Medicines List for Hospital Level, Paediatrics, 2017	
Newborn Care Charts Management of Sick and Small Newborns in Hospital SSN Version 1 - 2014	
Child, Youth and School Health	
South African Infant and Young Child feeding Policy (2013) (updated with circular in 2017)	
Non-Communicable diseases	
National User Guide on the Prevention and Treatment of Hypertension in Adults at PHC Level (2021)	
HIV	
Antiretroviral Treatment Clinical Guidelines for the Management of HIV in Adults, Pregnancy, Adolescents, Children, Infants and Neonates (2019)	
National HIV Testing Services Policy (2016)	
National Medical Male Circumcision Guidelines (2016)	
Standard Operating Procedures for Adherence Guidelines for HIV, TB and NCD (2020) AGL SOPs*	
National guidelines for the management of Viral Hepatitis (2019)	
TB	
National Tuberculosis Management Guidelines (2014)	
National Guidelines for the Management of Tuberculosis in Children (2013)	
Management of Rifampicin Resistance - A Clinical Reference Guide (2019)	

Women, Maternal and Reproductive Health	
Guidelines for Maternity Care in South Africa (2016)	
Cervical Cancer Prevention and Control Policy (2017)	
Clinical Guidelines for Breast Cancer Control and Management (2019)	
National Contraceptives clinical guidelines (2019)	
National Consolidated guidelines for the management of HIV in adults, adolescents, children and infants and prevention of mother-to-child transmission (2020)	
Maternal, Perinatal and Neonatal health policy (2021)	
Clinic Guideline for Genetics Services (2021)	
National Clinical Guidelines for Safe Conception and Infertility (2021)	
Total	
Total maximum possible score (sum of all scores minus those marked NA)	
Score (Total ÷ Total maximum possible score)	

Annexure 140: Checklist for element 218 – There is a functional Clinic committee

Use the checklist below to check whether the documents are available as evidence that the clinic committee is functional

Scoring – in column for score mark as follows:

Y (Yes) = present; **N** (No) = not present

Item	Score
Formal Appointment	
Signed appointment letters from Office of the MEC or delegated person	
Adopted and signed constitution as per provincial guidelines	
Code of conduct for Clinic/CHC Committee	
Training	
Attendance register for orientation and training conducted in the past 12 months	
Services Planning, Monitoring, Evaluation and meetings	
List of community needs as determined by the Clinic/CHC Committee in past 12 months	
Agendas indicating that community needs and progress against operation plan was discussed at least twice in the past 12 months	
Signed minutes indicating that the Clinic/CHC Committee was informed on the progress against the facility's operational plan at least twice in the past 12 months	
Current year plan indicating scheduled meetings (at least two within the next 12 months)	
Attendance registers show that meetings held formed a quorum	
Minutes of Clinic/CHC Committee meetings indicate that statistical data on population health indicators are discussed	
Minutes of Clinic/CHC Committee meetings indicate that the clinic's human resources situation is discussed	
Minutes of Clinic/CHC Committee meetings indicate that situation relating to equipment and , supplies is discussed	
Complaints, Compliments and Suggestion Management (check record of the past 6 months)	
Proof that Clinic/CHC Committee took part in opening complaints boxes according to stipulated schedule (signed register)	
Minutes indicate that the management of complaints, compliments and suggestions are discussed at Clinic/CHC Committee meetings	
Accountability and Communication	
Contact details of Clinic/CHC Committee members clearly displayed in reception area	
Total score	
Percentage (Total score ÷ 15) x 100	**%**

Annexure 141: Example of services and activities for an open day

Theme:	Immunisation/Child Health
Before the event:	Use health promoters to inform community about the event. Request community members to bring Road to Health Charts (RTHC).
MC:	Facility manager: Purpose of open day
Welcome speech:	Local Ward Counsellor
Opening speech:	MCWH coordinator: The importance of immunisation
MC:	Explain the activities offered
Activities:	Check RTHC Offer catch-up immunisation Screening height and weight Screening developmental milestones
Stations:	1. Screening 2. Immunisation 3. Facts and information about immunisation/ child health (with pamphlets) 4. Children's activities (colouring, face-painting, clowns, magicians)

Annexure 142: Example of a template for an operational plan

Name of Facility_____

Operational Plan _____(year)

DATE OF SUBMISSION: _____

SUBMITTED BY: _____ _____

Title Signature

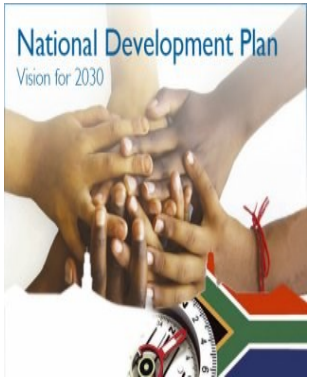
PURPOSE OF AN OPERATIONAL PLAN

An Operational Plan (OP) is created to assist you in meeting the aims and goals committed to in the District Health Plans/Annual Performance and Strategic Plans **through the development of strategic objectives**. An OP is there to assist you in breaking down exact activities for each objective that are required to meet your goals. By spending time on developing an accurate and useful OP, you can ensure that the objectives are achieved through regular monitoring. Activities are broken down into Quarters to assist with planning and prioritising.

Guidelines to follow when writing your OP:

1. Stick to the template provided- it has been created to assist you in creating streamlined work plans
2. All goals, objectives and indicators that the Programme has committed to in the Annual Performance Plan (APP) and Strategic Plan (SP) should be in the OP
3. Goals, objectives and indicators should appear in the same order in your APP, SP and OP to assist in alignment
4. Strategic objectives must be SMART (Specific, Measurable, Achievable, Realistic and Time bound)
5. NIDS must be used for all service delivery indicators.

HEALTH SECTOR PLANNING HORIZON



Provincial/Local Government

Medium Term Strategic Framework

Provincial/Local Government

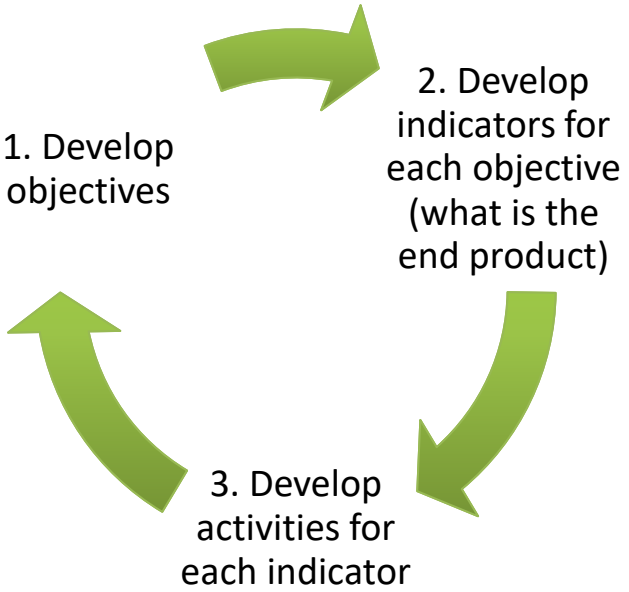
5 Year Strategic Plans

Provincial/Local Government

Annual Performance Plans and District Health Plans

OPERATIONAL PLANS

The template in the following pages gives guidance on how to go about to develop an operational plan. The flow diagram below sets out the process:



Strategic objectives can be grouped in two categories:

1. Those objectives that are standard and will remain more or less the same for mostly every year to ensure that healthcare services are delivered in the facility. These objectives relates to the specific services rendered at the facility. For example the facility could set an objective for each of the three streams of care (chronic, acute and mother and child health). Each objective will then have various indicators and each indicator will have a list of activities that needs to be performed to reach the objective

2. Those objectives that relates to the quality improvement plan of the facility. The quality improvement plan must be used to develop objectives to close the gaps as identified in the quality improvement plan.

STRATEGIC OBJECTIVES:

NAME OF DISTRICT:		**SUB DISTRICT:**	
STRATEGIC OBJECTIVES	(write down the strategic objectives for the facility, they can have more than 3) 1. 2. 3.		
INDICATORS FOR STRATEGIC OBJECTIVE 1: (Note an indicator does not have to have numeric values. An indicator can for example be a SOP for ....., the objective would then be to develop an SOP for ....). If this is the case at the field for numerator and denominator insert Not Applicable' (NA)	**INDICATOR 1**: Write down the name of the indicator (add additional lines if there are more that 2 indicators set to achieve the specific objective) .	**NUMERATOR:**	**DENOMINATOR:**
	INDICATOR 2:	**NUMERATOR:**	**DENOMINATOR:**
INDICATORS FOR STRATEGIC OBJECTIVE 2:	**INDICATOR 3:** .	**NUMERATOR:**	**DENOMINATOR:**
	INDICATOR 4:	**NUMERATOR:**	**DENOMINATOR:**
INDICATORS FOR STRATEGIC OBJECTIVE 3:	**INDICATOR 5:**	**NUMERATOR:**	**DENOMINATOR:**
	INDICATOR 6:	**NUMERATOR:**	**DENOMINATOR:**
INDICATORS FOR STRATEGIC OBJCTIVE 4:	**INDICATOR 7:**	**NUMERATOR:**	**DENOMINATOR:**
	INDICATOR 8:	**NUMERATOR:**	**DENOMINATOR:**

ANNUAL TARGETS SET PER QUARTER FOR EACH INDICATOR

ANNUAL TARGET		QUARTER 1 : TARGET / MILESTONE	QUARTER 2 : TARGET / MILESTONE	QUARTER 3 : TARGET/ MILESTONE	QUARTER 4 : TARGET/ MILESTONE
Indicator #	**Indicator name**				
INDICATOR 1:					
INDICATOR 2:					
INDICATOR 3:					
INDICATOR 4:					
INDICATOR 5:					
INDICATOR 6:					
INDICATOR 7:					
INDICATOR 8:					

ACTIVITIES SET TO ACHIEVE EACH INDICATOR

INDICATOR 1	**Name of indicator:**							
ACTIVITIES These must be actual activities, with only one activity per line	**PERSONS RESPONSIBLE** The person directly responsible for ensuring activity happens (must be an actual person)	**TIME FRAME** Mark with an 'X' the Quarter in which the activity will take place				**OUTPUTS** This is what is expected to happen should the activity take place	**ACTIVITY BUDGET**	
		Q1 (April-Jun 2017)	**Q2 (July-Sept 2017)**	**Q3 (Oct-Dec 2017)**	**Q4 (Jan-Mar 2018)**		**SOURCE** Where the money is coming from	**AMOUNT** In South African Rands

INDICATOR 2	**Name of indicator:**							
ACTIVITIES These must be actual activities, with only one activity per line	**PERSONS RESPONSIBLE** The person directly responsible for ensuring activity happens (must be an actual person)	**TIME FRAME** Mark with an 'X' the Quarter in which the activity will take place				**OUTPUTS** This is what is expected to happen should the activity take place	**ACTIVITY BUDGET**	
		Q1 **(April-Jun 2017)**	**Q2** **(July-Sept 2017)**	**Q3** **(Oct-Dec 2017)**	**Q4** **(Jan-Mar 2018)**		**SOURCE** Where the money is coming from	**AMOUNT** In South African Rands

INDICATOR 3	**Name of indicator:**							
ACTIVITIES These must be actual activities, with only one activity per line	**PERSONS RESPONSIBLE** The person directly responsible for ensuring activity happens (must be an actual person)	**TIME FRAME** Mark with an 'X' the Quarter in which the activity will take place				**OUTPUTS** This is what is expected to happen should the activity take place	**ACTIVITY BUDGET**	
		Q1 **(April-Jun 2017)**	**Q2** **(July-Sept 2017)**	**Q3** **(Oct-Dec 2017)**	**Q4** **(Jan-Mar 2018)**		**SOURCE** Where the money is coming from	**AMOUNT** In South African Rands

INDICATOR 4	**Name of indicator:**								
ACTIVITIES These must be actual activities, with only one activity per line	**PERSONS RESPONSIBLE** The person directly responsible for ensuring activity happens (must be an actual person)	**TIME FRAME** Mark with an 'X' the Quarter in which the activity will take place				**OUTPUTS** This is what is expected to happen should the activity take place	**ACTIVITY BUDGET**	
		Q1 **(April-Jun 2017)**	**Q2** **(July-Sept 2017)**	**Q3** **(Oct-Dec 2017)**	**Q4** **(Jan-Mar 2018)**		**SOURCE** Where the money is coming from	**AMOUNT** In South African Rands

INDICATOR 5	**Name of indicator:**								
ACTIVITIES These must be actual activities, with only one activity per line	**PERSONS RESPONSIBLE** The person directly responsible for ensuring activity happens (must be an actual person)	**TIME FRAME** Mark with an 'X' the Quarter in which the activity will take place				**OUTPUTS** This is what is expected to happen should the activity take place	**ACTIVITY BUDGET**	
		Q1 **(April-Jun 2017)**	**Q2** **(July-Sept 2017)**	**Q3** **(Oct-Dec 2017)**	**Q4** **(Jan-Mar 2018)**		**SOURCE** Where the money is coming from	**AMOUNT** In South African Rands

INDICATOR 6	**Name of indicator:**								
ACTIVITIES These must be actual activities, with only one activity per line	**PERSONS RESPONSIBLE** The person directly responsible for ensuring activity happens (must be an actual person)	**TIME FRAME** Mark with an 'X' the Quarter in which the activity will take place				**OUTPUTS** This is what is expected to happen should the activity take place	**ACTIVITY BUDGET**	
		Q1 **(April-Jun 2017)**	**Q2** **(July-Sept 2017)**	**Q3** **(Oct-Dec 2017)**	**Q4** **(Jan-Mar 2018)**		**SOURCE** Where the money is coming from	**AMOUNT** In South African Rands

INDICATOR 7	**Name of indicator:**							
ACTIVITIES These must be actual activities, with only one activity per line	**PERSONS RESPONSIBLE** The person directly responsible for ensuring activity happens (must be an actual person)	**TIME FRAME** Mark with an 'X' the Quarter in which the activity will take place				**OUTPUTS** This is what is expected to happen should the activity take place	**ACTIVITY BUDGET**	
		Q1 **(April-Jun 2017)**	**Q2** **(July-Sept 2017)**	**Q3** **(Oct-Dec 2017)**	**Q4** **(Jan-Mar 2018)**		**SOURCE** Where the money is coming from	**AMOUNT** In South African Rands

INDICATOR 8	**Name of indicator:**							
ACTIVITIES These must be actual activities, with only one activity per line	**PERSONS RESPONSIBLE** The person directly responsible for ensuring activity happens (must be an actual person)	**TIME FRAME** Mark with an 'X' the Quarter in which the activity will take place				**OUTPUTS** This is what is expected to happen should the activity take place	**ACTIVITY BUDGET**	
		Q1 **(April-Jun 2017)**	**Q2** **(July-Sept 2017)**	**Q3** **(Oct-Dec 2017)**	**Q4** **(Jan-Mar 2018)**		**SOURCE** Where the money is coming from	**AMOUNT** In South African Rands

Annexure 143: Status Determination Cycle

IDEAL CLINIC STATUS DETERMINATION CYCLE

All facilities

District PPTICRM (SD PPTICRM)

- Completed and captured by **31 July**
- Facility manager can conduct a Facility Manager SD to identify gaps to correct weaknesses where she/he is able to
- Facility manager asks for assistance to correct weaknesses from PPTICRM where required
- District PPTICRM analyses status of facilities in their district on the software and effect the required interventions to address weaknesses
- For facilities targeted to be IDEAL, district PPTICRM effects the intervention required to ensure that targeted facilities will be found to be Ideal by the peer reviewers

Facilities targeted to be IDEAL in the specific financial year

Cross district PPTIRCM peer reviews (SD PPTICRM PR)

- Completed and captured between **October and November**
- Celebrate the achievements of clinics found to be Ideal (silver and higher status)
- Facility management and district PPTICRM correct weaknesses in those still not Ideal

Facilities targeted to be IDEAL in the specific financial year that failed the PEER REVIEWS

District peer review updates (SD PPTICRM PRU)

- Completed and captured by **31 March**
- Effect final corrective interventions and capturing of final scores for financial year

PPTICRM = Perfect Permanent Team for Ideal Clinic Realisation and Maintenance

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Annexure 144: Example of a register for ambulance turnaround times

Facility name: _____

Request date	Request time	Clinician who made the request	Patient name and surname	Date of birth	ID number	Reason for referral	Arrival time	Name of responding officer	Actual turnaround time

Annexure 145: Checklist for element 224: Register for emergency transport requests is available

Use the checklist below to check that the details for emergency transport requests have been recorded

Scoring – in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant; NA = for gateway clinics that is attached to a hospital

Item	Score
Date of the request	
Details (name, surname, date of birth/age/ID number) of the user for whom the request was made.	
Reason for referral	
Time the ambulance requested	
Time the ambulance arrived	
Total	
Score (Total ÷ 5)	

Annexure 146: Checklist for element 227: SOP available for the handover between facility and EMS

Use the checklist below to verify that the SOP describes the topics as listed

Scoring – in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant; NA = for gateway clinics that is attached to a hospital.**Item**	**Score**
Documentation of EMS arrival time	
Documentation of handover time	
Method of transfer of patient from facility to ambulance	
Identification of patients	
Maternal clinical condition	
Monitoring of maternal vital signs	
Documentation of clinical condition of baby (where relevant)	
Documentation of treatment and interventions	
Monitoring of patient during transfer	
The receiving facility expecting the patient	
Name of the health care provider who accepted the transfer at the facility expecting the patient	
Documentation of known medical history	
Transfer letter and/or maternity records to be handed over to the receiving facility	
The name and designation of the health care provider receiving the patient	
Signatures of transferring and receiving personnel	
Target time frames for the completion of patient hand over	
Total	
Score (Total ÷ 16)	

Annexure 147: Checklist for element 229: District referral SOP is available

Use the checklist below to verify that the SOP describes the topics as listed

Scoring – in column for score mark as follows:

Y (Yes) = compliant; **N** (No) = not compliant

Item	Score
District referral network	
Referral register	
Standardised patient referral form	
Standardised patient referral feedback form	
Total	
Score (Total ÷ 4)	

Annexure 148: Example of a register for patient referrals

Date referred	Patient details (name and surname, file record number)	Name of referring health care practitioner	Name of facility referred to (destination)	Reason for referral	Date feedback received	Feedback from referral destination

Annexure 149: Checklist for element 230: There is a referral register that records referred patients

Use the checklist below to verify that the referral register contains the details as listed below

Scoring – in column for score mark as follows:

Check – Use the referral register

Y (Yes) = compliant; **N** (No) = not compliant

Item	Score
Name of referred patient	
Name of referring facility	
Name of referring health care practitioner	
Name of receiving facility	
Reason for referral	
Date referred	
Totals	
Scores (Totals ÷ 7)	

Annexure 150: Checklist for element 231: Copy of referral form available in the patient record

Use the checklist below to verify that the referral forms were completed in full

Scoring – in column for score mark as follows:

Check – Use the referral register and randomly select three records of patients that were referred

Y (Yes) = compliant; **N** (No) = not compliant

Item on referral form	**Score Record 1**	**Score Record 2**	**Score Record 3**
Name of patient			
Name of referring institution			
Name of referring health care practitioner			
Name of receiving institution			
Summary of clinical details			
Total			
Total maximum possible score (sum of all scores minus those marked NA)			
Score (Total ÷ Total maximum possible score)			

Annexure 151: Reporting template for implementing partners

Name of organisation: _____

Person reporting: _____

Date of meeting: _____

Objective 1:			
Activity	Progress	Challenges	Mitigation actions

Planned activities for next quarter

_____

_____

_____

Annexure 152: Template for compiling a list of organizations that provide health related services

Name of organisations	Name of contact person	Telephone number	Physical address	Type of service provided

Annexure 153: Template for memorandum of understanding

MEMORANDUM OF UNDERSTANDING

MADE AND ENTERED INTO BY AND BETWEEN

THE _____ DEPARTMENT OF HEALTH

(herein after referred to as “the Department”)

Represented by _____

in his/her capacity as Head of Department.

AND

South African Police Service (SAPS)

Herein after referred to as the “other Department”

represented by _____

in his/her capacity as Provincial Police Commissioner

A. PREAMBLE

Since the launch of the government's green paper on National Health Insurance, various reforms and initiatives are underway to improve services to be provided under the future National Health Insurance. This includes the three streams of re-engineering of primary health care, strengthening management of health facilities, upgrading of infrastructure, setting and monitoring national quality standards, and establishing norms for staffing levels and skill-mix. The 'Ideal Clinic' (IC) programme is another initiative as a way of systematically improving the deficiencies in Primary Health Care clinics in the public sector and to correct the deficiencies in quality.

In order to implement these health reforms and specifically to realize the Ideal clinic concept; the assistance and cooperation of other stakeholders are necessary. It is also necessary to formalize this relationship formally.

It is therefore necessary that the two Departments agree on certain commonalities, assistance and cooperation to be provided, to effect better service delivery priorities to the community in the _____

B. MEMORANDUM OF UNDERSTANDING

1. Preamble included in Memorandum of Understanding

The preamble of this understanding forms part hereof, as if specifically mentioned herein.

2. Purpose of Memorandum of Understanding

The purpose of the Memorandum of Understanding is to ensure the continued cooperation and communication exist between the Department of Health and the South African Police Service.

3. INTERPRETATION

Unless inconsistent with the context, this agreement shall be interpreted as follows:

3.1 The head notes to the various clauses of this MOU and the index are inserted for reference purposes only, and shall not take precedent in the interpretation of this MOU;

3.2. This MOU shall be governed by the laws of the Republic of South Africa;

3.3. Unless inconsistent with the context, an expression which denotes:

3.3.1 Any gender includes the other gender;

3.3.2 A person shall include both a natural person and/or a juristic person and vice versa;

3.3.3 The singular includes the plural and vice versa;

3.3.4 “District Clinical Specialist Team” (DCST) means a team of specialist comprising of a family Physician, an anesthetist, an obstetrician and gynecologist, an advance midwife, a primary health care practitioner and a pediatric nurse, placed in a health district to strengthen the clinical services within the health district

3.3.5 “Department” means the Department of Health, a duly constituted department of the Provincial Government in the _____ Province;

3.3.6 “Facilities” means the health facilities as agreed to by the Parties;

3.3.7 “Ideal Clinic” means a primary health care facility with good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes and adequate bulk supplies that use applicable policies, protocols, guidelines as well as partner and stakeholder support , to ensure the provision of quality health services to the community

3.3.8 “National Health Insurance” is defined by the World Health Organization as the progressive development of a health system including its financing mechanisms into one that ensures that everybody has access to quality health services and where everyone has accorded protection from financial hardships linked to accessing these health services

3.3.9 “Other Department“means the Department with whom the Department of Health sought to have an understanding and is a party of this MOU

3.3.10 “Primary Health Care” means the first level of contact of

individuals, the family and the community with the national health system, care as close as possible to where people live and work, and constitutes the first element of a continuing health care service

3.3.11 "Municipal Ward base outreach team" is a team of community health workers based at a Primary Health Care facility and offers integrated services to households and individuals within its catchment area. The catchment area refers to the different Wards within Municipalities. The team provides health care to families/ households; community outreach services; preventative, promotive, curative, palliative and rehabilitative services

3.3.12 "Upgrading of facility" means the improvement of the physical infrastructure of the health facility

4. Commencement and duration of Memorandum of Understanding

4.1 This MOU shall commence from the date of the last signature effected hereto and shall remain in force for a period of five (5) years.

4.2 The Parties may in writing agree to extend the period of this MOU.

4.3 Either Party may terminate this MOU by giving the other Party three (3) months written notice.

5. Duties of the Department of Health

The Department shall:

- Ensure that its facilities are secure by providing proper fencing, perimeter lightning, and security guard houses with security guards.
- Ensure that all health facilities have the contact detail of the local SAPS for their respective areas
- Inform SAPS of any matter that may or have cause a risk to the patients, staff or property of the Department.
- Work together with the SAPS when any matter at the facility need to be investigated.
- Ensure regular communication with the SAPS on a local level through the attendance of multisector forums in respective areas.

6. Duties of the South African Police Service

- To assist the Department of Health to ensure the safety of patients, staff and the property of the Department when called upon
- To assist where necessary, if practically possible to monitor security and safety at health facilities by way of regular patrols near health facilities such as clinics, community health centers and mobile clinics
- To inform the Department where security risks have been identified and where necessary advise on measures that would improve the security
- To investigate reported crime at facilities and to provide feedback to the Department in accordance with internal police prescripts
- To engage the Department and relevant stakeholders forums on issues of safety and security at health facilities.
- To provide reasonable access to SAPS at the workplace without compromising service delivery in order for the Department to promote health activities and health service delivery to the employees.
- To invite SAPS where reasonably possible when organizing internal health promotions and other relevant programmes to ensure maximum benefit to employees.

7. Oversight Joint Committee

7.1 HOD's of the respective Departments to meet at Provincial forums and address issues pertaining both Departments that may hamper service delivery

7.2 Local coordination between the head of the facility and the local colleague from the South African Police Service to meet and provide oversight at a local level

8. GOOD FAITH

In all their interactions the Parties shall display good faith, a spirit of co-operation, show diligence, professionalism and commitment.

9. Breach and termination

9.1 Should any Party (Defaulting Party) commit any breach of the terms of this MOU and fail to remedy such breach within fourteen (14) days of receiving a written notice of breach.

9.2 A Notice of breach shall:-

9.2.1 Indicate clearly the nature and extent of such breach;

9.2.2 Contain a demand that the Defaulting Party remedies the breach within 14 days after receiving such notice; and

9.2.3 Draw the attention of the Defaulting Party to the remedies the Aggrieved Party may use if such demand is not heeded.

10. Dispute resolution

10.1 The Heads of Department shall try to resolve any difference or dispute relating to this Agreement which may arise between the Parties within fourteen (14) days of becoming aware of its existence.

10.2 Where the Parties are unable to resolve any difference or dispute amicably such difference or dispute shall be referred for arbitration in terms of the Arbitration Act No 42 of 1965.

10.3 The findings of the arbitrator shall be final and binding on the Parties.

11. Variations

This MOU is the only understanding between the Parties and no amendments or variations to this MOU shall be of any force or effect unless reduced to writing and signed by both parties.

12. General

12.1 If any provision of this MOU is or becomes illegal, void or invalid it shall not affect the legality of the other provisions, unless its illegality or otherwise renders the whole MOU unenforceable.

12.2 Neither party shall assign or otherwise transfer any of its rights or obligations under this MOU without prior written consent of the other party which shall not be unreasonable withheld.

12.3 Neither party will be liable for any failure to meet any of its responsibilities in terms of this MOU or any delay in meeting them to the extent to which the failure or delay is caused by any circumstance what so ever which is beyond its reasonable control, including but not limited to strikes, lockout, war, Civil commotion or any order or regulation of any government or other lawful authority meeting the above requirements

13. Domicilium Citandi et Executandi

13.1 The Parties choose as their Domicilia Citandi et Executandi their respective addresses set out in this clause at which addresses all processes and notices arising out of or in connection with this Agreement may validly be served upon or delivered to the Parties.

13.2 The Parties respective addresses are as follows:

Department of Health, Province:

Postal Address:

Street Address:

Tel:

South African Police Service: Province:

Postal Address:

Street Address:

Tel:

13.3 Any notice given in terms of this Agreement shall be deemed to have been received by the addressee;

13.3.1 If delivered by hand on the date of delivery.

13.3.2 If posted be prepaid registered mail, on the eighth (8^{th}) day following the date of such posting.

13.4 Notwithstanding anything to the contrary contained or implied in this Agreement a written notice or communication actually received by one of the Parties from another including by way of facsimile transmission shall be adequate written notice or communication to such Party.

13.5 Either Party is entitled to change the address to another address in South Africa as long as it is not a post box (*post restante*) provided that such address shall be used fourteen (14) days after the notice was sent to the other Party.

For the District health services:	**For the District Environmental Health Services :**
Full Names and Surname:	Full Names and Surname:
Designation:	Designation:
Signature:	Signature:
Date:	Date:
Place:	Place:
AS WITNESSES (Full Names and Surname): 1._____	AS WITNESSES (Full Names and Surname): 1._____
2. _____	2. _____