INTEGRATED CLINICAL SERVICES MANAGEMENT

ICSM

ACKNOWLEDGEMENT

The Department of Health would like to acknowledge the following individuals for their contribution to the development of the manual:

- Ms. Jeanette Hunter - Deputy Director General for Primary Healthcare for her oversight and leadership with respect to the Ideal Clinic Initiative
- Dr Shaidah Asmall - Senior Technical Advisor to National Department of Health for her extensive contribution to the conceptual development of the model, manual and tools
- Dr Ozayr Mahomed - Public Health Medicine Specialist - University of KwaZulu Natal for the development of the implementation framework and compilation of the manual
- Broadreach Healthcare Pty Ltd for their financial support

Funded by:

Disclaimer: This publication was produced for review by the United States Agency for International Development. It was prepared by Dr Shaidah Asmall, Senior Technical Advisor, who provided overall conceptual and technical editorial guidance and Dr Ozayr Mahomed of the Discipline of Public Health Medicine at the University of KwaZulu-Natal. The contents expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

INTEGRATED CLINICAL SERVICES MANAGEMENT

FOREWORD

Primary Healthcare forms the backbone of the Healthcare delivery system in South Africa and a means of achieving Universal Health Coverage. An Ideal Clinic concept 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, guide¬lines 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.

In October 2014 Operation Phakisa was launched to develop a plan to scale up the Ideal Clinic Realisation and Maintenance across South Africa. Operation Phakisa proposed that the package of services should evolve to ensure a comprehensive set of services guided by the principle of dealing with the whole lifecycle (from pre-birth to death). There should be a continuum of care from health promotion to palliative care and integrated clinical services should provide the platform for service delivery.

The purpose of this manual is to provide a step-by-step guide for Ideal Clinic Realisation and Maintenance (ICRM) champions and facility managers on how to implement Integrated Clinical Services Management thereby improving the process flow within facilities, and quality of clinical care. This manual needs to be read in conjunction with the Integrated Chronic Disease Management Manual and the Ideal Clinic Manual and does not replace any approved clinical guidelines and protocols.

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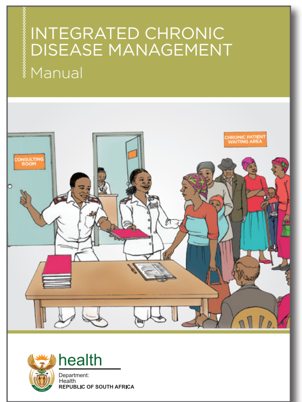
ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune deficiency Syndrome
ANC	Antenatal Care
APC/PC101	Adult Primary Care/Primary Care 101 Guidelines
ART	Antiretroviral treatment
CCMDD	Central Chronic Medicing Dispensing and Distribution
CHW	Community Health Worker
DCST	District Clinical Specialist Team
DHIS	District Health Information System
EML	Essential Medicine List
HIV	Human Immunodeficiency Virus
HPRS	hHealth Patient Registration System
ICDM	Integrated Chronic Disease Manua
ICRM	Ideal Clinic Realisation and Maintenance
ICSM	Integrated Clinical Services Management
MC&SRH	Maternal Child and Sexual Reproductive Health
MTCT	Mother to Child Transmission
IMCI	Integrated Management of Childhood Illness
IPC	Infection Prevention and Control
NCD	Non-communicable diseases
NDP	National Development Plan
NDoH	National Department of Health
NHLS	National Health Laboratory Services
NHI:	National Health Insurance
PHC	Primary Healthcare
PuPs	Pick-up Points
QIP	Quality Improvement Plan
SAHR:	South African Health Review
SANC	South African Nursing Council
TB	Tuberculosis
UTT	Universal Test and Treat
WBPHCOT	Ward Based Primary Healthcare Outreach Team

MANUAL PURPOSE

The purpose of this manual is to provide a step-by-step guide for Ideal Clinic Realisation and Maintenance (ICRM) champions and facility managers on how to improve the process flow within facilities, and how to improve quality of clinical care. This manual needs to be read in conjunction with the 'Integrated Chronic Disease Management' (ICDM) manual and the 'Ideal Clinic Manual' and does not replace any approved clinical guidelines and protocols.



MANUAL ORGANISATION

Integrated Clinical Service Management (ICRM) aims to assist facilities to achieve compliance with Domain 2 of the 'National Core Standards' as well as seven of the 32 Ideal Clinic sub-components and 55 indicators.

The manual provides both a theoretical perspective on all components of the ICSM manual as well as practical steps for the implementation of ICSM.

Section 1: Background provides an explanation of the ICRM concept, the link with the 'National Core Standards for Health Establishment', the Ideal Clinic dashboard and the concept of Integrated Clinical Services.

Section 2: Overview describes the various components and the principles relating to Health Service Re-organisation; Clinical Support Management component; 'Assisted Self-management' component in the South African context; Population Health dimension of the ICSM and the health system strengthening requirements.

Section 3: Pre-implementation preparedness details all the pre-implementation requirements including change management, data collection, data analysis and the development of an action plan.

Section 4: Health Service Re-organisation provides a step-by-step guide on re-organising the facility from both the administrative and service perspective.

Section 5: Clinical Management Support describes the clinical tools that are available to support the optimal management of patients at a Primary Healthcare level.

Section 6: 'Assisted Self-management' defines the role of community healthcare workers and links with population awareness.

Section 7: Monitoring and evaluation – describes the tools and methodology for monitoring and evaluating ICSM.

PRE-IMPLEMENTATION
- BRIEFING OF STAFF
- SELECTION OF START DATE
- FACILITY ICSM TEAM
- COMMUNITY AWARENESS

DATA COLLECTION
- FACILITY WALK THROUGH
- FACILITY DATA COLLECTION
- WAITING TIME SURVEY
- HUMAN RESOURCE TRAINING AUDIT

DATA ANALYSIS
- NUMBER OF PATIENTS TO BE BOOKED DAILY
- NUMBER OF CONSULTATION ROOMS PER STREAM
- PROCESS FLOW
- HUMAN RESOURCE TRAINING REQUIREMENTS
- MANAGEMENT OF PATIENT RECORDS

ADMINISTRATIVE RE-ORGANISATION
- CREATING A SAFE ENVIRONMENT
- SIGNAGE (INTERNAL AND EXTERNAL)
- SINGLE ADMINISTRATIVE POINT
- MANAGEMENT OF APPOINTMENTS

SERVICE RE-ORGANISATION
- FOUR STREAMS OF CARE
- APPOINTMENTS
- FAST QUEUE
- CCMDD OR PRE-DISPENSING
- DOWN REFERRAL

CLINICAL MANAGEMENT SUPPORT
- CLINICAL GUIDELINES AND TOOLS
- CLINCIAL STATIONERY & PATIENTS RECORDS
- TRAINING OF STAFF
- DR & DISTRICT CLINICAL SPECIALIST TEAM

'ASSISTED' SELF- MANAGEMENT
- COLLABORATION WITH WARD BASED OUTREACH TEAM
- HOUSEHOLD VISITS
- ADHERENCE CLUBS AND SUPPORT GROUPS

POPULATION HEALTH AWARENESS & SCREENING
- HEALTH AWARENESS DAYS
- UNIVERSAL TEST AND TREAT
- INTEGRATED SCHOOL HEALTH TEAM
- WARD BASED OUTREACH TEAMS

MONITORING AND EVALUATION
- WAITING TIME SURVEY
- PATIENT EXPERIENCES SURVEY
- CLINICAL AUDIT
- PERFORMANCE INDICATORS
- ADHERENCE TO APPOINTMENTS SURVEY
- DASHBOARD

PRE-IMPLEMENTATION PREPAREDNESS

HEALTH SERVICE RE-ORGANISATION

STRENGTHENING INDIVIDUAL AND POPULATION HEALTH

SECTION ONE
BACKGROUND

This section of the manual provides a background to the context of health service delivery in South Africa, the challenges to achieving the vision of a long and healthy life for all South Africans and introduces the concept of ***Integrated Clinical Services Management***.

The ***Integrated Clinical Services Model*** is then presented at the conclusion of the section.

INTRODUCTION

The Government of South Africa has embarked on a phased implementation of National Health Insurance (NHI) in order to achieve universal health coverage – access to appropriate, affordable, efficient quality health services[1]. The District Health System Model, with primary healthcare (PHC) as a platform for delivery of health services, is the main implementation mechanism (Figure 1).

PHC clinics are the first point of contact between the population and the health system. PHC clinics act as a gatekeeper to higher levels of care and need to promote good health outcomes, rather than simply serve those in ill-health by offering a curative service.

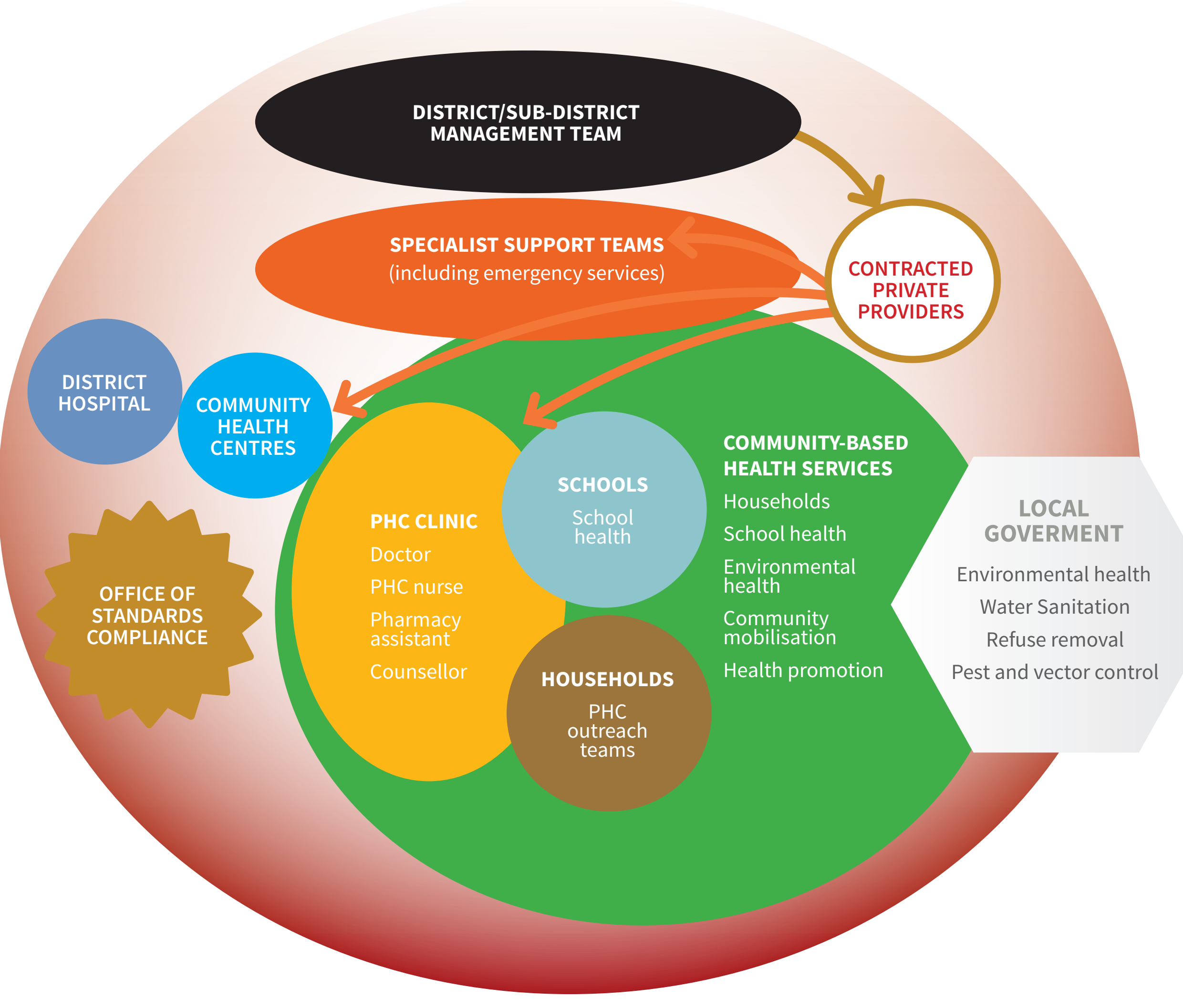


FIGURE 1: PHC RE-ENGINEERING FRAMEWORK BASED ON DISTRICT HEALTH SYSTEM

1.1. BACKGROUND

The attainment of a long and healthy life for all South Africans is a key outcome of the vision of the South African Government[(2)]. In addition, the National Development Plan (NDP) also envisages that, by 2030, South Africa should have[(3)] accomplished the following:

- Raised the life expectancy rate to at least 70 years for men and women.
- Produced a generation of under-20s that is largely free of HIV.
- Reduced the burden of disease.
- Progressively improved TB prevention and cure.
- Achieved an infant mortality rate of fewer than 20 deaths per thousand live births, including an under-5 mortality rate of less than 30 per thousand.
- Achieved a significant shift in the equality, efficiency, effectiveness and quality of healthcare provision.
- Achieved universal health coverage.
- Significantly reduced the risks posed by the social determinants of disease and adverse ecological factors.

In order to improve health outcomes, a number of pro-active health policies and legislation have been gazetted and implemented, better health system management, in terms of service delivery and infrastructure and strategic priority programmes for HIV & AIDS, prevention of maternal to child transmission and tuberculosis (TB) amongst others have been strengthened [(4)].

LEGISLATION AND GAZETTED POLICIES	BETTER HEALTH SYSTEM MANAGEMENT
Free primary healthcare Essential drugs programme Choice on termination of pregnancy Anti-tobacco legislation Community service for graduating health professionals	Greater parity in district expenditure Clinic expansion and improvement Hospital revitalisation programme Improved immunisation programme Improved malaria control

TABLE 1: KEY HEALTH INDICATORS FOR SOUTH AFRICA-2011-2016 (SOURCE- STATSA)

	2011	2013	2016
Life expectancy (females)	54,6 years	61,4 years	65,1 years
Life expectancy (males)	50,2 years	57,7 years	59,7 years
Crude birth rate	23,5	22,9	21,6
Infant mortality rate (per 1000 live births)	39,7	37,7	33,7
Under-5 mortality rate	55,6	51,3	44,4
Crude death rate	11,7	10,2	9,7
HIV prevalence	11,8	12,2	12,7
Incidence of HIV	1,59	1,39	1,27
Maternal mortality (per 100 000)	203	141	

Prevention of mother to child transmission

Mother to child transmission (MTCT) of HIV declined from 8 per cent in 2009 to 2.7 percent in 2012[5]. In 2015, more than 95% of HIV-positive pregnant women received antiretroviral medicine to reduce the risk of MTCT. As a result, MTCT of HIV in South Africa has fallen to 1.5%, meeting the current NSP target[6].

Antiretroviral treatment

Between March 2011 and March 2014, the number of people on antiretroviral therapy (ART) grew from 1.69 million to 2.68 million, an increase of about 278 660 patients per year with just over 3 million (3 103 902) people of all ages receiving ART by end of 2014/2015[7].

Tuberculosis

The incidence of TB has declined from 832 per 100 000 populations in 2009 to 593 per 100 000 in 2014[8]. The TB cure rate for smear positive pulmonary cases improved from 75,8% in 2012 to 76,8% in 2013[8]. The TB loss to follow-up declined from 6,2% in 2012 to 5,8% in 2013[8].

PREVENTION AND CONTROL OF EPIDEMICS	ALLOCATION OF RESOURCES	HEALTH SYSTEMS MANAGEMENT
1 Prevention and treatment of HIV/AIDS 2 Prevention of new epidemics (esp.MDR-TB) 3 Prevention of alcohol abuse	4 Distribution of financing and spending 5 Availability of health personnel in the public sector	6 quality of care 7 Operational efficiency 8 Devolution of authority 9 Health worker morale 10 Leadership and innovation

Despite the significant financial investment and the implementation of numerous innovative programmes to transform the health sector, a number of key challenges, including: • the quadruple burden of disease • concerns about quality of services • inefficiency and ineffectiveness of the health system and • spiralling costs especially in the private sector[9] limit the attainment of the objectives of the Department of Health.

Burden of disease

South Africa is experiencing four simultaneous epidemics of communicable, non-communicable, perinatal and maternal, and injury-related disorders. These are referred to as the quadruple burden of diseases[10]. According to the second 'National Burden of Disease' study 2010, HIV and TB were the most common cause of mortality followed by non-communicable diseases, infectious and other parasitic diseases and injury related deaths[11].

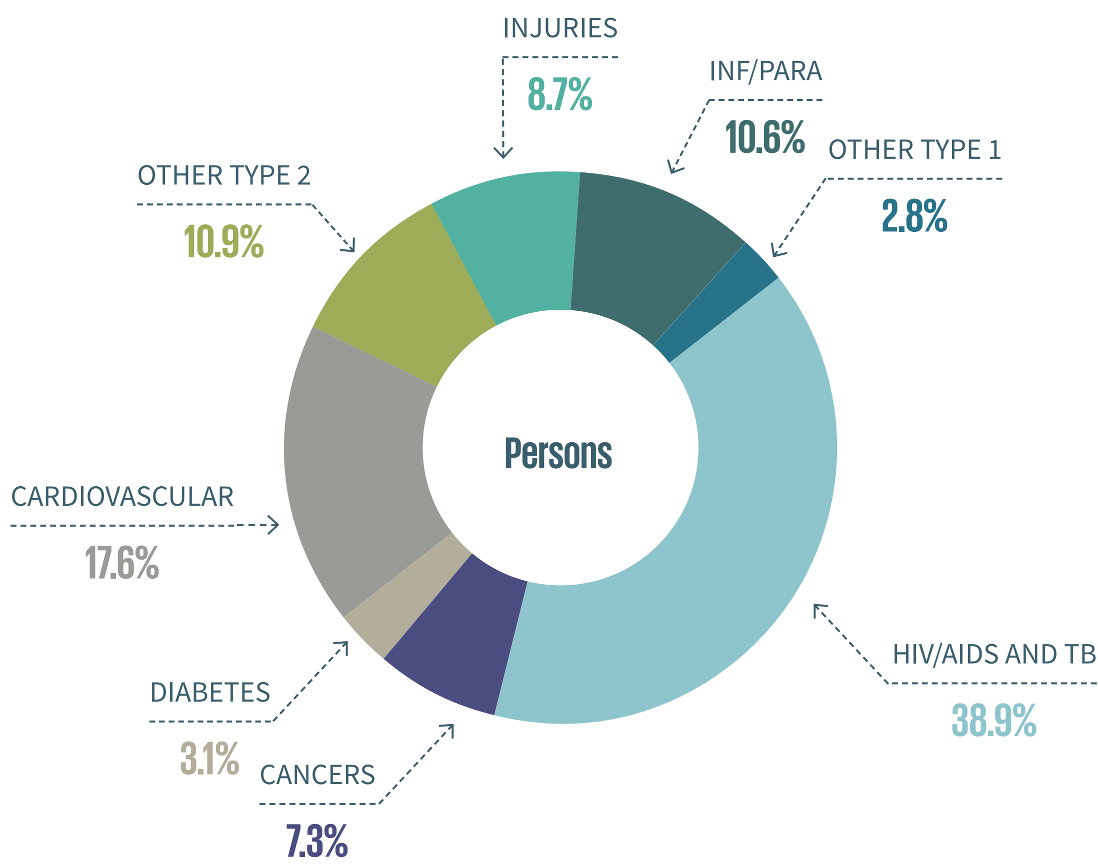


FIGURE 2: DEATH BY DISEASE CATEGORIES-2010 (SOURCE: SECOND NATIONAL BURDEN OF DISEASE STUDY FOR SOUTH AFRICA: CAUSE OF DEATH PROFILE 1997-2010)

Figure 3 below displays the leading causes of deaths across all the age groups.

RANK	AGE 0-4 YEARS	AGE 5-14 YEARS	AGE 15-44 YEARS	AGE 45-59 YEARS	AGE 60+ YEARS	ALL AGES
1	HIV/AIDS 27.8%	HIV/AIDS 49.1%	HIV/AIDS 58.7%	HIV/AIDS 39.2%	Cerebro-vascular disease 15.4%	HIV/AIDS 35.0%
2	Diarrhoeal diseases 18.9%	Road injuries 11.2%	Interpersonal violence 7.0%	Cerebro-vascular disease 6.1%	Hypertensive heart disease 9.4%	Cerebro-vascular disease 6.8%
3	Lower respiratory infections 11.7%	Meningitis/ encephalitis 4.5%	Road injuries 5.5%	Tuberculosis 5.5%	Ischaemic heart disease 9.3%	Lower respiratory infections 4.4%
4	Preterm birth complications 10.4%	Lower respiratory infections 3.9%	Tuberculosis 4.1%	Ischaemic heart disease 4.6%	HIV/AIDS 8.7%	Ischaemic heart disease 4.3%
5	Birth asphyxia 5.2%	Diarrhoeal diseases 3.7%	Self-inflicted injuries 2.4%	Diabetes mellitus 3.7%	Diabetes mellitus 6.4%	Hypertensive heart disease 4.0%
6	Protein-energy malnutrition 4.4%	Drowning 3.5%	Meningitis/ encephalitis 2.4%	Hypertensive heart disease 3.5%	Lower respiratory infections 6.0%	Tuberculosis 3.9%
7	Sepsis/other newborn infectious 2.8%	Interpersonal violence 2.0%	Lower respiratory infections 1.9%	Road injuries 2.8%	COPD 3.8%	Diarrhoeal diseases 3.4%
8	Septicaemia 1.7%	Epilepsy 1.9%	Cerebro-vascular disease 1.3%	Lower respiratory infections 2.8%	Tuberculosis 3.7%	Interpersonal violence 3.1%
9	Meningitis/ encephalitis 1.5%	Tuberculosis 1.9%	Renal disease 1.1%	Interpersonal violence 2.1%	Diarrhoeal diseases 2.6%	Diabetes mellitus 3.1%
10	Road injuries 1.5%	Fires, hot substances 1.5%	Diarrhoeal diseases 1.0%	COPD 1.9%	Renal disease 2.4%	Road injuries 3.1%

FIGURE 3: THE LEADING CAUSES OF DEATHS ACROSS ALL THE AGE GROUPS GROUPS (SOURCE: SECOND NATIONAL BURDEN OF DISEASE STUDY FOR SOUTH AFRICA: CAUSE OF DEATH PROFILE 1997-2010)

Maternal deaths

Approximately 5 929 maternal deaths occurred during the period 2008 to 2010. Indirect maternal causes most likely due to HIV were the main cause of maternal mortality (41,8%) followed by hypertension and maternal haemorrhage (Figure 4)[11].

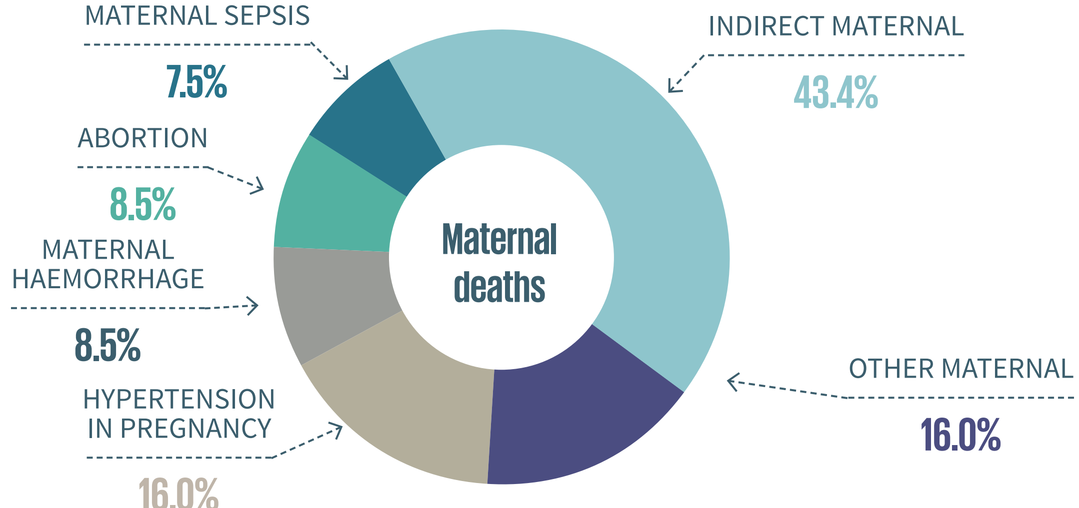


FIGURE 4: MATERNAL DEATHS BETWEEN 2008 AND 2010 (SOURCE: SECOND NATIONAL BURDEN OF DISEASE STUDY FOR SOUTH AFRICA: CAUSE OF DEATH PROFILE 1997-2010)

Children under-5 mortality

An estimated 60 505 under-5 child deaths occurred in 2010. HIV and AIDS was the leading cause of death, followed by neonatal causes of death, diarrhoeal diseases and lower respiratory tract infections[11].

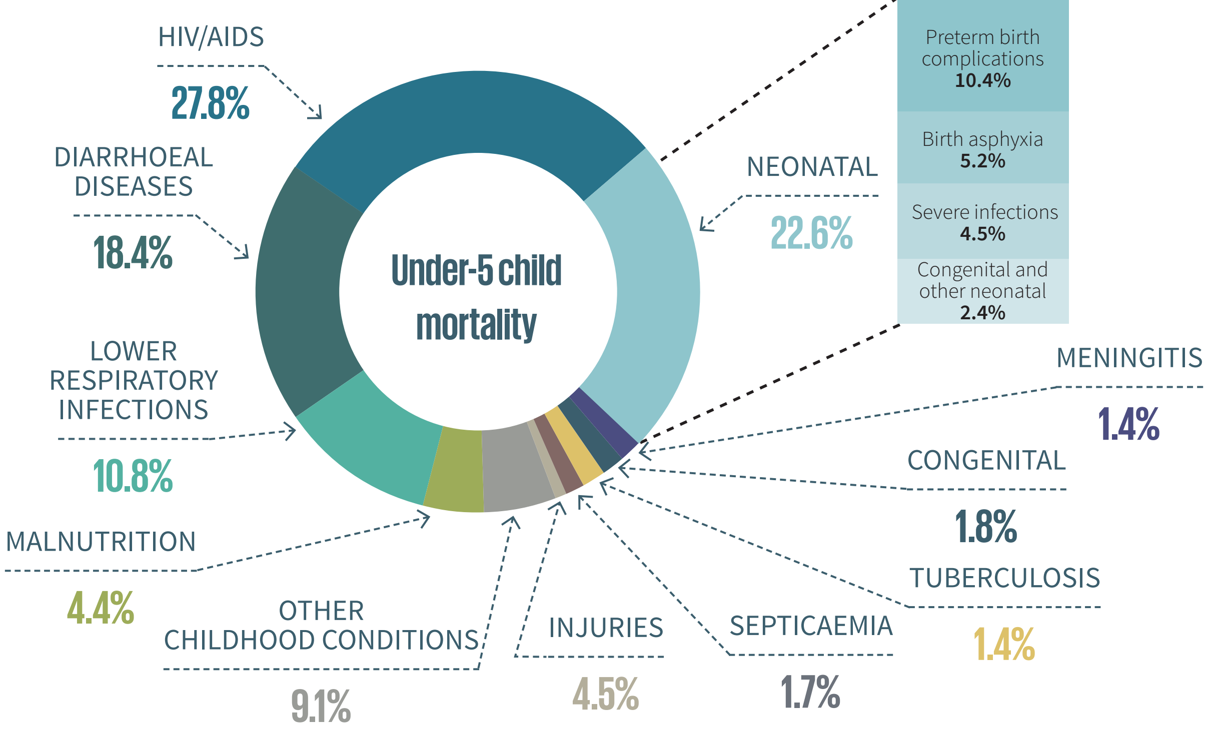


FIGURE 5: CAUSES OF UNDER-5 CHILD MORTALITY DEATHS 2010 (SOURCE: SECOND NATIONAL BURDEN OF DISEASE STUDY FOR SOUTH AFRICA: CAUSE OF DEATH PROFILE 1997-2010)

Quality of services

The 'National Health Facilities Baseline Audit' conducted in 2012, indicated the following key findings[12]:

Facility classification

Facilities were found to be functioning differently from their classification status.

Quality of services

Facilities scored less than 50% compliance with vital measures in patient Safety and Security (34%) and Positive and Caring Attitudes (30%). The priority area waiting times scored the highest compliance to vital measures at 68%. Primary care facilities on average scored lower than hospitals in all priority areas.

Functionality of services

The compliance score obtained by the country's facilities is the lowest for Clinical Services (38%). Within Clinical Services, the area of Health Technology recorded the lowest compliance for both PHC and hospital facilities followed by pharmacy.

Range of services

Dental services are lacking across the board at PHC level, an issue that needs to be addressed, PHC facilities should offer more therapeutic services such as audiology, speech therapy and psychology, as the majority of patients accessing these services have to be referred to a higher level of care.

Physical infrastructure

The management of facility infrastructure requires attention, especially at PHC level.

Medicines and supplies management

PHC facilities throughout the country show a high percentage failure in compliance to the vital measure dealing with the availability of medicines as per the Essential Drug List.

Waiting times

A client satisfaction survey conducted by the Public Service Commission in July 2011[13] showed patients were least satisfied with the timeliness of service, indicating that waiting times were a significant issue (Figure 6). There have been reports of wide variations in patients' waiting times, with some patients waiting for a duration of seven hours.

LEVEL OF SATISFACTION WITH SERVICES RENDERED BY THE DEPARTMENT OF HEALTH

Satisfaction Rating

Service	Satisfaction Rating
Outcome	83
Value for money	81
Fairness and equity	77
Knowlege and competence of staff	65
Facilities	64
Information	58
Courtesy	53
Accessibility	52
Timeliness	34
Redress	27

IDEAL CLINIC PILOT SITE #1

THERE IS A HUGE VARIANCE IN WAITING TIMES

Percentage of patients seen in x hours

2 hours or less: 43.4%

2-5 hours: 43.4%

6+ hours

IDEAL CLINIC PILOT SITE #1

Some patients wait almost 7 hours in the clinic

Number of hours

	Minimum	Maximum
Number of hours	0h32	6h49

IDEAL CLINIC PILOT SITE #2

Some patients wait almost 7 hours in the clinic

Number of hours

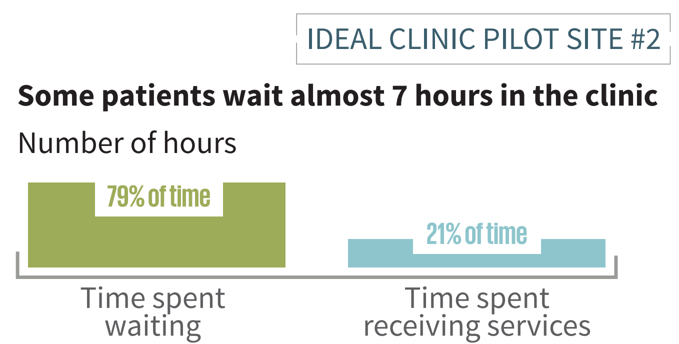


FIGURE 6: CITIZEN SATISFACTION SURVEY (SOURCE: OPERATION PHAKISA)[14]

Operational inefficiencies and health system challenges:

A baseline assessment conducted between April 2011 and November 2011 across the 42 PHC facilities in three specified districts (Dr Kenneth Kaunda, North west province; West Rand Health District, Gauteng and Bushbuckridge sub-district, Ehlanzeni district, Mpumalanga) to review the organisation of services, noted the following operational inefficiencies:[15]

1

Vertical nature of services

Clinical services were delivered in a vertical manner within a designated area and consultation rooms provided for HIV positive patients that were separate from all other patients in all three districts. Designated consultation rooms and designated professional nurses that managed patients by specific programmes .

2

Service not offered daily

There were specific days for consulting chronic non-communicable diseases (NCD) patients i.e. service was not offered daily.

3

Inefficient process flow at all facilities

a) All patients wait in one area for vital signs monitoring- resulting in bottlenecks and extending patient waiting times

b) No signage directing patients to appropriate area for waiting

c) No patient scheduling mechanism in place - Patients were given only return dates for follow-up-thus inappropriate staff allocation.

d) No mechanism for tracking defaulters

Figure 7 below depicts the typical scenario that a 35 year old HIV positive women with a six month old baby will experience at the clinic:

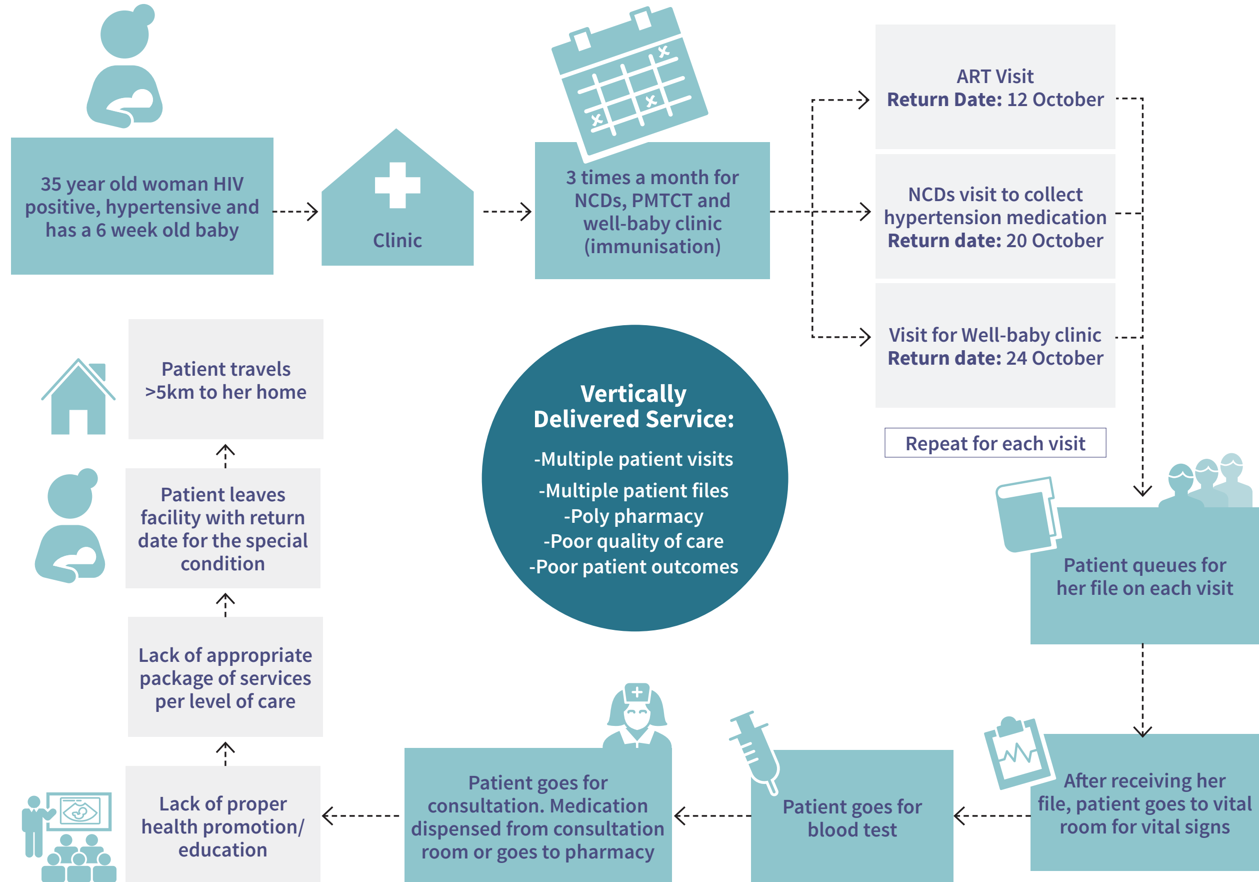


FIGURE 7: TYPICAL PROCESS FLOW FOR A PATIENT AT PHC CLINICS (SOURCE: OPERATION PHAKISA) [14]

1.2. PROBLEM STATEMENT

Many patients by-pass clinics to attend hospitals for their initial contact visits, and often receive primary level care at expensive tertiary institutions[3]. The most often cited reasons for patients by-passing the primary point of care include overcrowded facilities, long waiting times, medication stock out, insufficient and inappropriately trained human resources with poor attitudes, poorly structured and inaccessible PHC clinics[4].

These factors limit the attainment of the objectives of transforming the health sector.

1.3. GOVERNMENT'S RESPONSE TO ADDRESS CHALLENGES IN PHC

In 2013 the Ideal Clinic Initiative (which became the ICRM) was developed to address deficiencies in primary healthcare clinics and establish a systematic approach to transform all PHC facilities to conform to NHI standards, as defined by the Office of Health Standards Compliance.

An Ideal Clinic is therefore 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 health services to the community. An Ideal Clinic cooperates with other government departments as well as with the private sector and nongovernmental organisations to address the social determinants of health[16].

In October 2014 Operation Phakisa was launched to develop a plan to scale up the ICRM across South Africa[14]. Operation Phakisa proposed that the package of services should evolve to ensure a comprehensive set of services guided by the principle of dealing with the whole lifecycle (from pre-birth to death). There should be a continuum of care from health promotion to palliative care. There should also be a level of care from within the community up to the district hospital[14].

An ***Ideal Clinic*** is on 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 health services to the community.

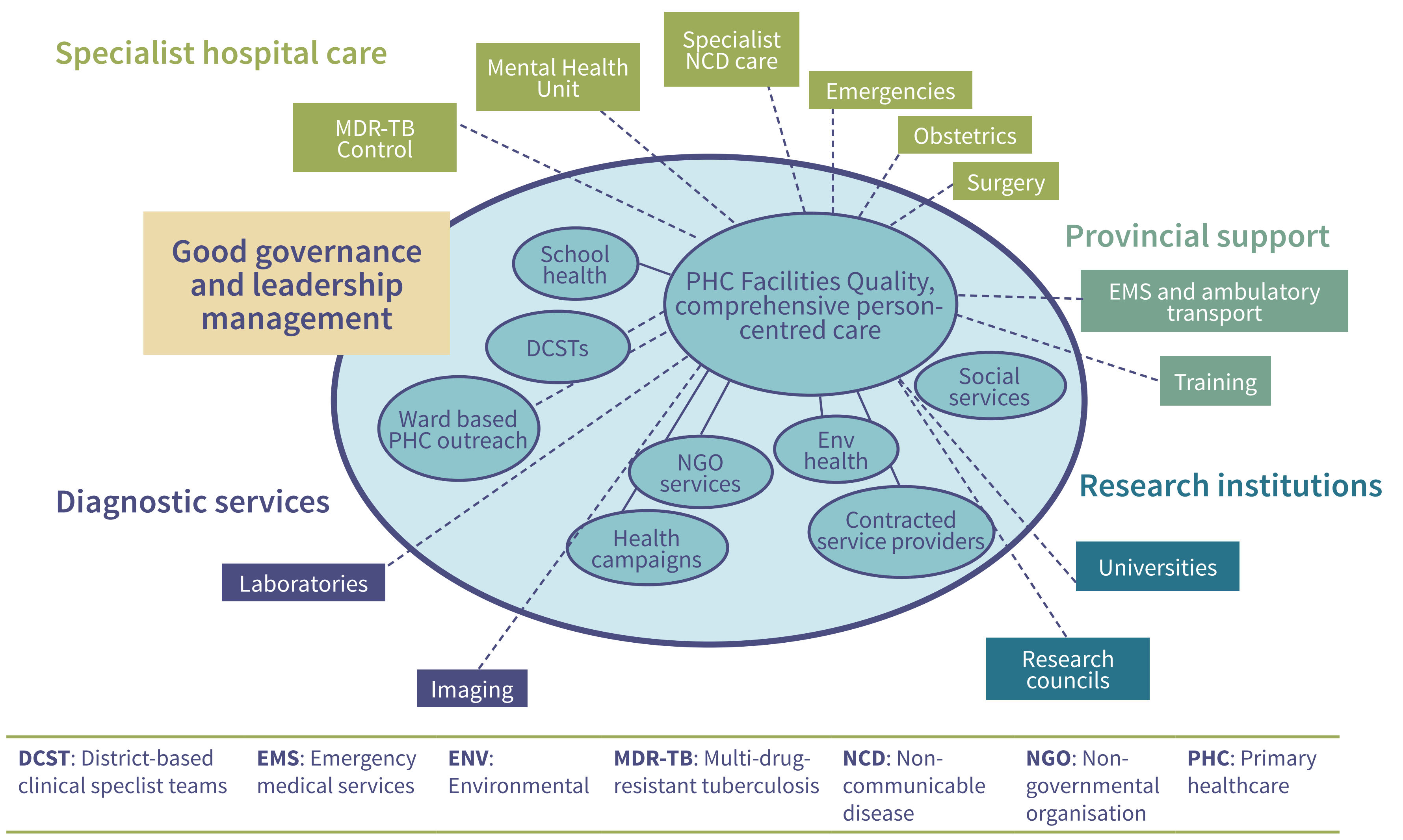


FIGURE 8: PHC IDEAL CLINIC CONCEPT (SOURCE: SAHR: 2014/15-CHAPTER 2-PAGE 25)

In order to achieve the status of an Ideal Clinic, a number of components and sub-components will need to be adhered to (see figures 8 and 9). ICSM is the central pillar of health service delivery and will be a key focus within the Ideal Clinic. ICSM aims to assist facilities to achieve compliance with Domain 2 of the 'National Core Standards' as well as seven of the 32 Ideal Clinic sub-components and 55 indicators.

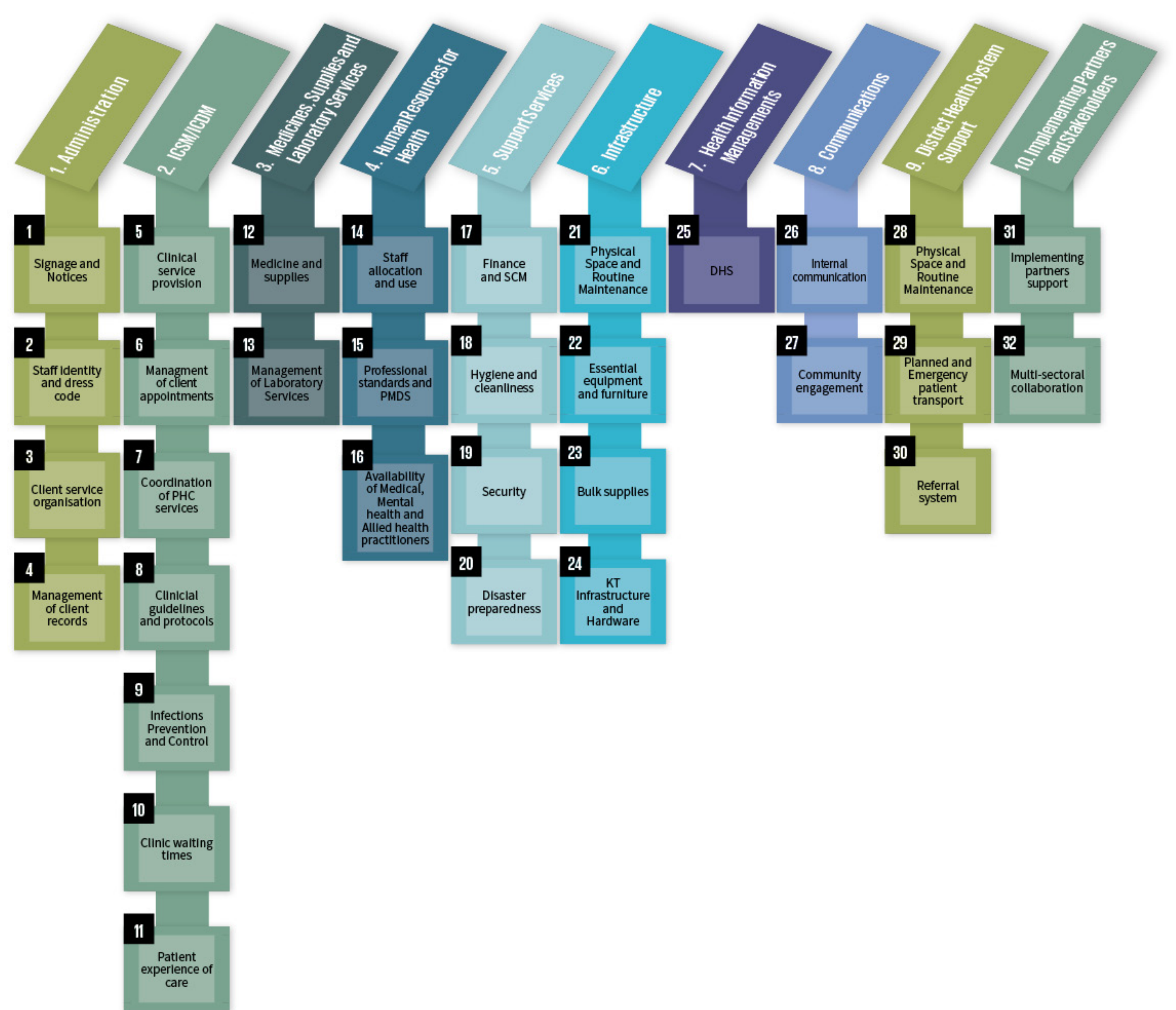


FIGURE 9: IDEAL CLINIC COMPONENTS AND SUBCOMPONENTS (SOURCE: NDOH)

DOMAIN 2 OF THE 'NATIONAL CORE STANDARDS'

DOMAIN 2: PATIENT SAFETY AND CLINICAL GOVERNANCE AND CLINICAL CARE — 2. Integrated Clinical Services Management (ICSM)

No.	Standard					
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						
22	The facility has been reorganised with designated consulting areas and staffing for acute, chronic health conditions and preventative health services.	E	☺	HF		
23	Patient are consulted, examined and counselled in privacy	I	☺	HF		
24	TB treatment success rate is at least 85% or has increased by at least 5% from the previous year	E	🕮	HF		
25	TB (new pulmonary) defaulter rate < 5%	E	🕮	HF		
26	Ante-natal visit rate before 20 weeks gestation is at least 67% or has increased by at least 5% from the previous year	E	🕮	HF		
27	Ante-natal patient initiated on ART rate is at least 96% or has increased by at least 5% from the previous year	E	🕮	HF		
28	Immunisation coverage under one year (annualised) is at least 87% or has increased by at least 5% from the previous year	E	🕮	HF		
30	Quality Improvements plans are signed off by the facility manager and updated quarterly	I	🕮	HF		
31	Six monthly district/sub-district clinical performance review report with action plan from clinical quality supervisors 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						
32	Patients have access to a medical practitioner	E	🕮	HF		
33	Patients have access to oral health services	I	🕮	D		
34	Patients have access to occupational therapy services	I	🕮	D		
35	Patients have access to physiotherapy services	I	🕮	D		
36	Patients have access to dietetic services	I	🕮	D		
37	Patients have access to social work services	I	🕮	D		
38	Patients have access to radiography services	I	🕮	D		
39	Patients have access to ophthalmic service	I	🕮	D		
40	Patients have access to mental health services	E	🕮	D		
41	Patients have access to speech and hearing services	I	🕮	D		
42	Staff dispensing medicine have access to the support of a pharmacist	I	🕮	D		
43	Adolescent and youth friendly services are provided	I	🕮	D	Y	
7. Management of patient appointments: Monitor whether an ICSM patient appointment system is adhered to						
44	An ICSM compliant patient appointment system for patients with chronic health conditions and MCWH patient is in use	I	🕮	HF		
45	The records of booked patients are pre retrieved not later than the day before the appointment	I	☺	HF		
46	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	E	? ☺	HF		
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						
47	Facility does referrals to and receive referrals from school health services in its catchment area	I	🕮	D		
48	The facility refers patients with chronic but stable health conditions to home- and community-based services for support	E	🕮	HF		
49	Facility refers environmental health related risks to environmental health services	I	🕮	D	Y	

Domain	Sub-domain		No.	Criterion					
DOMAIN 2: PATIENT SAFETY AND CLINICAL GOVERNANCE AND CLINICAL CARE	2. Integrated Clinical Services Management (ICSM)	**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**							
			50	The ICSM compliant package of clinical guidelines is available in all consulting rooms	E	🕮	HF	**Y**	
			51	National guidelines on priority health conditions are available in the facility	I	🕮	HF	**Y**	
			52	80% of professional nurses have been fully trained on Adult Primary Care OR Practical Approach to Care Kit	E	🕮	D		
			53	80% of professional nurses have been fully trained on Integrated Management of Childhood illness	E	🕮	D		
			54	Resuscitation protocol is available	E	🕮	HF		
			55	80% of professional nurses have been trained on Basic Life Support	E	🕮	D		
			56	The National Guideline for Patient Safety Incident Reporting and Learning is available	E	🕮	NDoH		
			57	The patient safety incident records show compliance to the National Guideline for Patient Safety Incident Reporting and Learning	E	🕮	HF	**Y**	
			58	The National Clinical Audit guideline is available	E	🕮	NDoH		
			59	Clinical audits are conducted quarterly on priority health conditions	E	🕮	HF		
			60	Clinical audit meetings are conducted quarterly in line with the guidelines	E	🕮	HF		
			61	National guidelines are followed for all notifiable medical conditions	I	?🕮	HF		
		10. Infection prevention and control: Monitor whether prescribed infection prevention and control policies and procedures are adhered to							
			62	The National Policy on Infection Prevention and Control is available	E	🕮	NDoH		
			63	Facility has a designated staff member who is assigned the with the infection prevention and control role	E	🕮	HF		
			64	Standard Operating Procedure on infection control standard precautions is available	I	🕮	HF		
			65	All staff has received in-service training on infection control standard precautions that is in-line with the Standard Operating Procedure in the last two years.	E	🕮	HF	**Y**	
			66	Poster on hand washing is displayed above the hand wash basin in every consulting room	I	🕮	HF		
			67	Annual awareness day on hand hygiene is held	I	🕮	HF		
			68	Poster on cough etiquette is displayed in every waiting area	I	🕮	HF		
			69	Staff wear appropriate protective clothing	E	?☺	HF	**Y**	
			70	The linen in use is clean	E	☺	HF		
			71	The linen is appropriately used for its intended purpose	E	☺?	HF		
			72	Waste is properly segregated	E	☺	HF		
			73	Sharps are disposed of in impenetrable, tamperproof containers	V	☺	HF		
			74	Sharps containers are disposed of when they reach the limit mark	V	☺	HF		
			75	Sharps containers are placed on work surface or in wall mounted brackets	E	☺	HF		
			76	An annual risk assessment for infection prevention and control compliance is undertaken by the designated staff member assigned with the infection prevention and control role	I	🕮	HF		

DOMA IN 2: PATIENT SAFETY AND CLINICAL GOVERNANCE AND CLINICAL CARE	2. Integrated Clinical Services Management (ICSM)								
		11. Patient waiting time: Monitor whether the facility's prescribed waiting times are adhered to							
			77	The National Policy for The Management Of Waiting Times is available	I		NDoH		
			78	The national target of not more the three hours for time spent in a facility is visibly posted	I		HF		
			79	Waiting time is monitored using the prescribed tool	E		HF		
			80	The average time that a patient spends in the facility is no longer than 3 hours	E		HF		
			81	Patients are intermittently informed of delays and reasons for delays in service provision	I	?	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							
			82	The National Patient Experience of Care Guideline is available	E		NDoH		
			83	The results of the yearly Patient Experience of Care Survey are visibly displayed at reception	E		HF		
			84	An average overall score of 70% is obtained in the Patient Experience Of Care Survey	E		HF		
			85	The results obtained from the Patient Experience Of Care Survey are used to improve the quality of service provision	E		HF		
			86	The National Guideline To Manage Complaints/Compliments/Suggestions is available	E		NDoH		
			87	The complaints/compliments/suggestions records show compliance to the National Guideline to Manage Complaints/Compliments/Suggestions	E		HF	Y	
			88	90% of complaints received are resolved	E		HF		
			89	90% of complaints received are resolved within 25 working days	E		HF		
			90	Complaints/compliments/suggestions boxes are visibly placed at main entrance/exit	E		HF		
			91	Official complaint/compliment/suggestion forms and pen are available	E		HF		
			92	A standardised poster describing the process to follow to lodge a complaint, give a compliment or make a suggestion is clearly sign posted next to the complaints/compliments/suggestions box, in at least two local languages	E		HF		

SOURCE: IDEAL CLINIC DEFNINITIONS, COMPONENTS AND CHECKLISTS, NDOH)

NDP GOALS AND PRIORITIES

NDP Goals 2030	NDP Priorities 2030	NDoH Strategic Goals 2014-2019
Average male and female life expectancy at birth increased to 70 years TB prevention and cure progressively improved Maternal, infant and child mortality reduced Prevalence of non-communicable diseases reduced Injury, accidents and violence reduced by 50% from 2010 levels	a. Address the social determinants that affect health and diseases d. Prevent and reduce the disease burden and promote health	Prevent disease and reduce its burden, and promote health
Health systems reforms completed	b. Strengthen the health system	Improve health facility planning by implementing norms and standards
		Improve financial management by improving capacity, contract management, revenue collection and supply chain management reforms
	c. Improve health information systems	Develop an efficient health management information system for improved decision making
	h. Improve quality by using evidence	
Primary healthcare teams deployed to provide care to families and communities		Re-engineer primary healthcare by: increasing the number of ward based outreach teams, contracting general practitioners, and district specialist teams; and expanding school health services
Universal health coverage achieved	e. Financing universal healthcare coverage	Make progress towards universal health coverage through the development of the National Health Insurance scheme, and improve the readiness of health facilities for its implementation
Posts filled with skilled, committed and competent individuals	f. Improve human resources in the health sector g. Review management positions and appointments and strengthen accountability mechanisms	Improve human resources for health by ensuring adequate training and accountability measures

SOURCE: STRATEGIC GOALS 2014-2019, NDOH

2. WHAT IS *INTEGRATED CLINICAL SERVICES MANAGEMENT*?

There are many definitions of integrated care or integrated Health services and as a result *Integrated Health Services* means different things to different people.

Integrated Health Services refers to:

'The organisation and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money(17)*.'*

Integrated care is holistic care, provided to a person based on the individual user's need, rather than a programmatic approach there is an awreness of their health as a whole, rather than only one clinical aspect of it. Integration of care involves arranging services so that they are not disjointed, and for the user it is care that is seamless, smooth and easy to navigate, rather than the organisation of services to suit the service provider. The services offered to the user are coordinated and there is a reduction number of stages in an appointment and the number of separate visits required to a health facility.

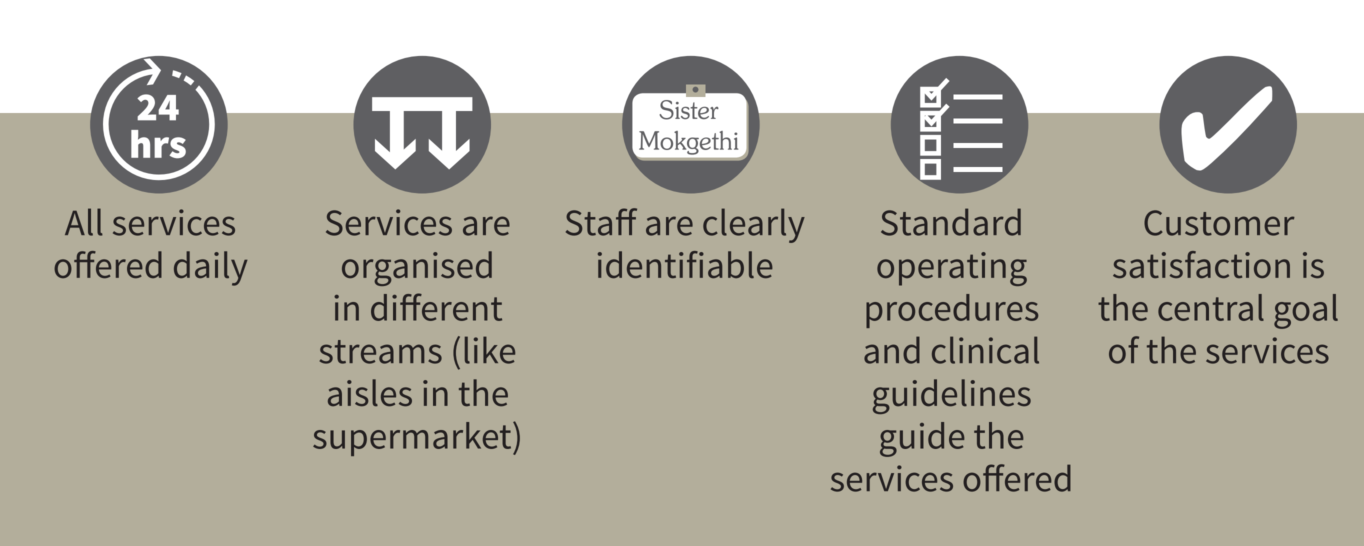
Integrated Clinical Services offered appropriately at the PHC has the potential to provide benefits for the patient, facility and the health system at large. (Table 2).

TABLE 2: BENEFITS OF INTEGRATED CLINICAL SERVICES

PATIENT PERSPECTIVE	FACILITY PERSPECTIVE	HEALTH SYSTEM PERSPECTIVE
• **Reducing number of facility visits – improve the patient's social and economic productivity** • **Improved quality of care will be received due to continuity of care being provided**	• Improved working environment due to the reduction in the overflow of patients • Decreased patient waiting times • Improvement in quality of care provided • standardised documentation and care guided by protocols	• Improved coordination of care between clinics and community • Improved efficiency in services delivered • Decreased costs due to standardised care and decreased interaction with health services • Strengthening of up and down referral system • Improved capacity of human resources

3. OVERVIEW OF THE ICSM MODEL

Integrated Clinical Services adopts a ***supermarket approach*** in the organisation and delivery of services. The supermarket approach refers to the following:



For example; a mother requiring services, and a child attending the facility, will receive services on the same day and not be provided with different appointment dates. Or a patient attending the clinic for family planning and also requiring a cervical smear will be provided the cervical smear on the same date and not be given a return appointment for a different date for the cervical smear.

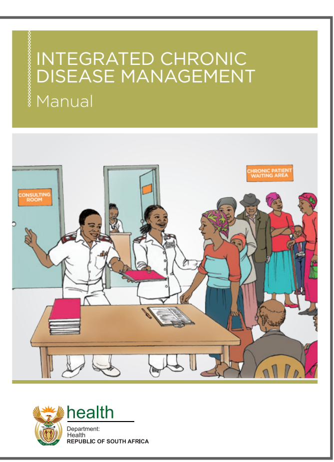
4. EXAMINING THE ICSM MODEL

WHY DO WE REQUIRE ICSM?

In order to improve patient health outcomes and operational efficiency, as well as patient satisfaction with health services, a patient-centric model of care is required.

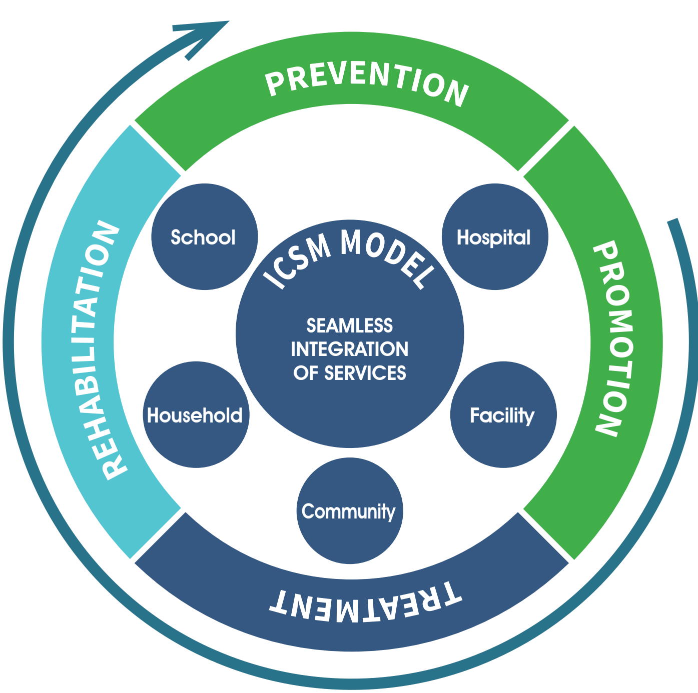
WHAT?

The ICSM utilises a health system strengthening approach and a patient-centric view to achieve operational efficiency at facility level, improved patient clinical outcomes and an informed population that takes individual responsibility for their health. The ICSM builds on the ICDM model.



WHERE?

The ICSM is premised on a *seamless integration of services* for patients between different levels of services (school, household, community, facility and hospital) and the continuum of care (prevention, promotion, treatment, rehabilitation).



WHEN?

The *first interaction will be at the primordial prevention level* through healthy living messages communicated through mass media and Integrated School Health Teams (ISHT). *Primary prevention* will be through facility based, school based and population based screening for early detectable and preventable conditions as well as health promotion. *Secondary prevention* will be provided at facility level through appropriate treatment and management of the patient's diagnosed condition and supportive assistance at the household level. *Tertiary prevention* will be provided, depending on the individual patients need, through supportive health services which will include palliative services if necessary.

WHO?

The ICSM has the patient as the primary focus. At a *facility level*, the patient will be treated and managed by a multi-sectorial team (doctors, nurses, pharmacist, rehabilitative practitioners, audiologist and dieticians) based on the patients individual clinical profile. At the *community level*, the patient will be assisted by health promoters, community healthcare workers and adherence clubs. At a *population level*, the patient will be exposed to mass media coverage addressing healthy living.

HOW?

The *implementation of ICSM* involves activities at the facility, service provider, management, community and population levels:

At a ***facility level*** the ICSM will be implemented through facility re-organisation, both at an administrative and service level. The patient process flow at the facility should be organised into three clearly designated areas that make it easy for patients to access and exit without any cross over. (See following page for a depiction of this.)

For ***service provider's*** standardised clinical tools, evidence based clinical guidelines and capacity development will be implemented.

At a ***management level*** it will involve ensuring good planning such that all the necessary components of the health system required for patient care are available.

At ***community level*** the ward based outreach teams will be capacitated to provide assisted management for patients, whilst the courier system encompassing the central chronic dispensary will be used to ensure medication delivery.

At a ***population level*** health awareness days will be used to convey important health messages.

This figure provides a graphic depiction of the model described above.

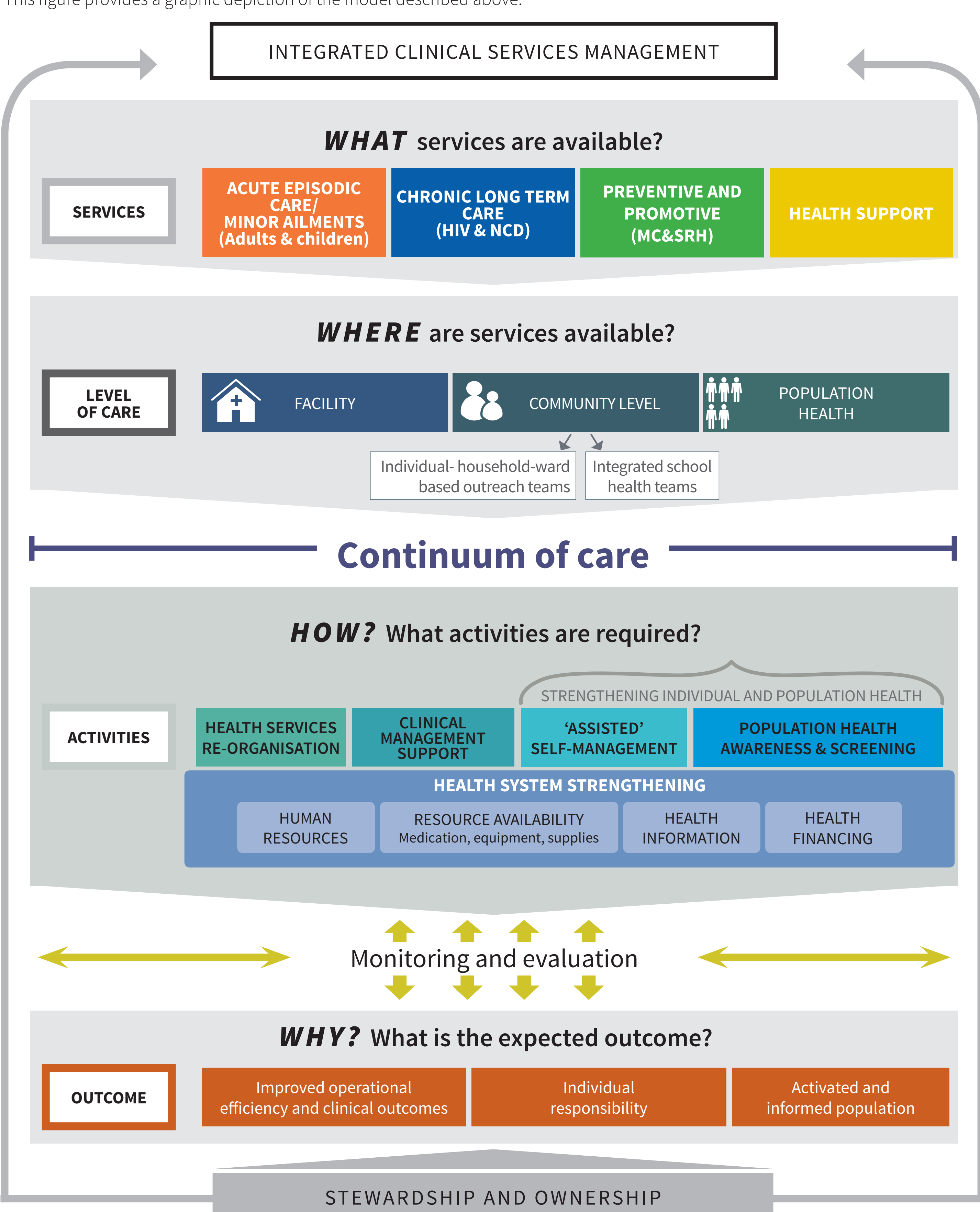
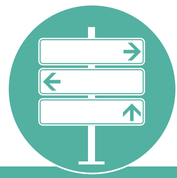


FIGURE 10: INTEGRATED CLINICAL SERVICE MANAGEMENT MODEL

SECTION TWO
OVERVIEW

This section focuses on the various components of the *ICSM model*.



HEALTH SERVICE RE-ORGANISATION

- Single administrative point
- Pre-appointment retrieval of clinical records
- Appointment scheduling
- Re-organisation of patient flow based on streams of care -**Integration of care**
  - Designated waiting areas
  - Designated vital signs station
  - Designated consultation rooms
- Pre-dispensing of medication/ CCMDD

CLINICAL MANAGEMENT SUPPORT

- Clinical guidelines and tools
- Clinical stationery & patients' records
- Clinical training
- Supervision and support by district clinical specialist teams

'ASSISTED' SELF-MANAGEMENT

- Health promotion and education at community level
- Identification of at-risk patients within the household
- Point of care testing and screening
- Support groups and adherence clubs
- Medication delivery (courier service)

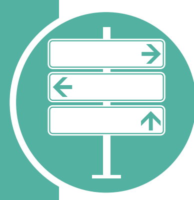
POPULATION HEALTH AWARENESS & SCREENING

- Health awareness campaigns
- Universal test and treat
- Social marketing.
- Screening services
- Integrated School Health Teams

HEALTH SYSTEM STRENGTHENING

- Human resources – capacity building and scheduling
- Medicine supply – stock management
- Equipment – essential equipment List
- Health information
- Advocacy and leadership

FIGURE 11: INTEGRATED CLINICAL SERVICE MANAGEMENT MODEL COMPONENTS

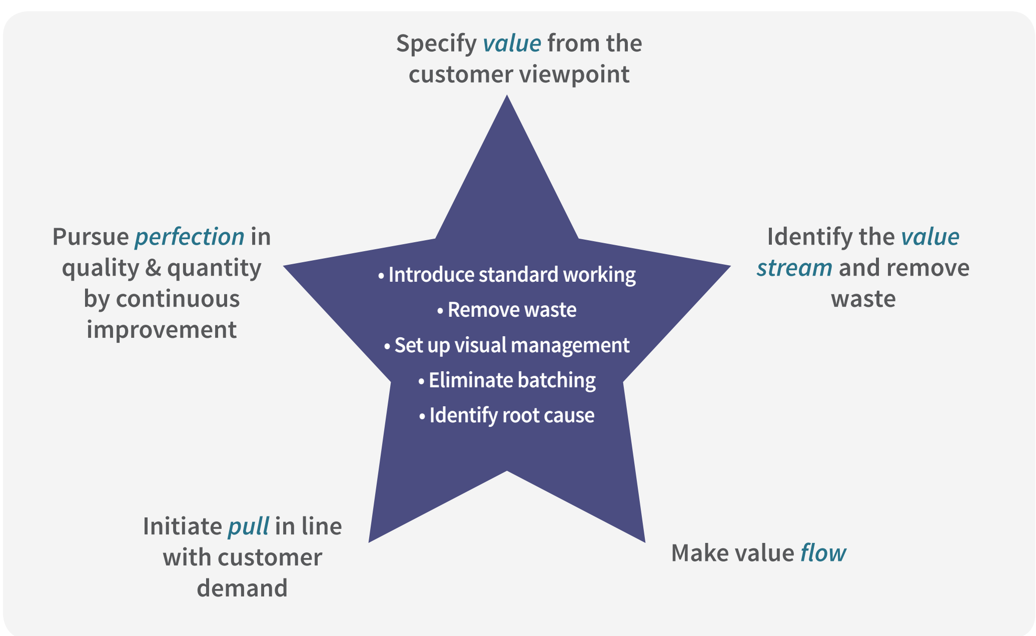


1. HEALTH SERVICE RE-ORGANISATION

Health service re-organisation focuses on the service delivery component and is premised on *lean thinking*.

Lean thinking is a process of eliminating waste with the goal of adding value by the identification of customer needs and it aims to improve processes by removing activities that are non-value-added (a.k.a. waste)[18].

Lean thinking is based on *five principles*: • Specify *value* • dentify the *value stream* steps • Make *value flow* • Supply what is *pulled* by the customer • pursue perfection by *continuous improvement*.



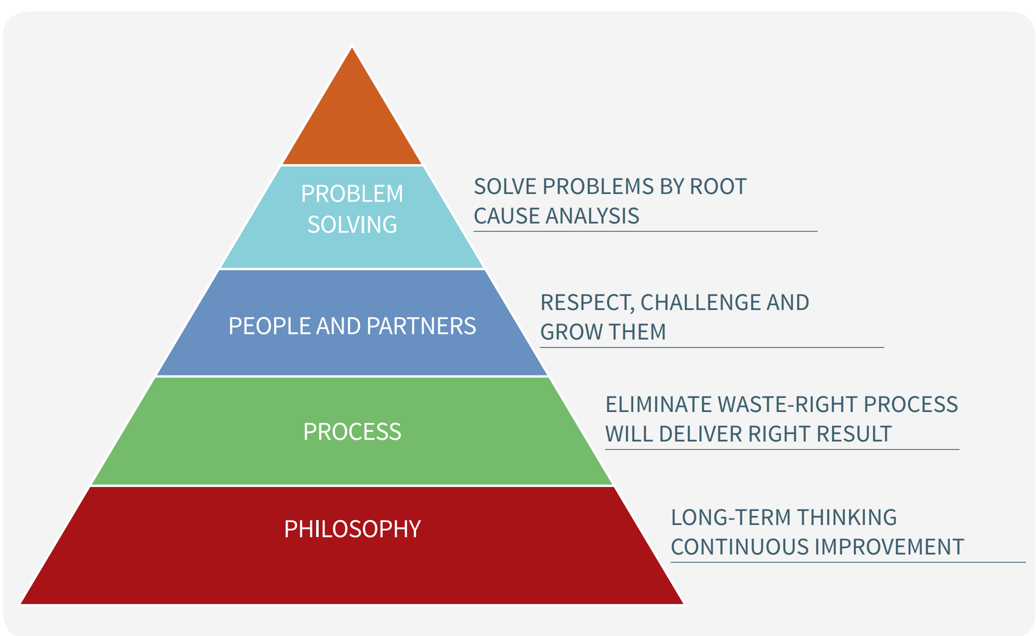
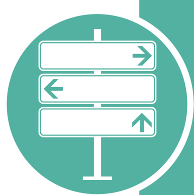
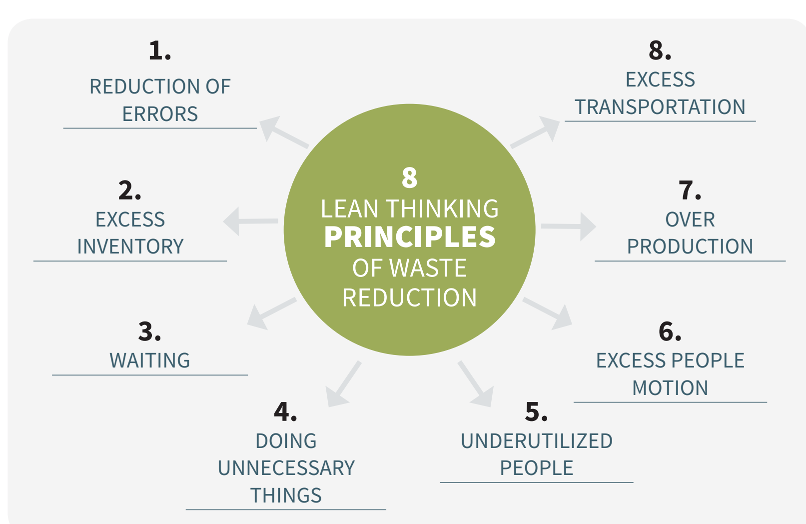
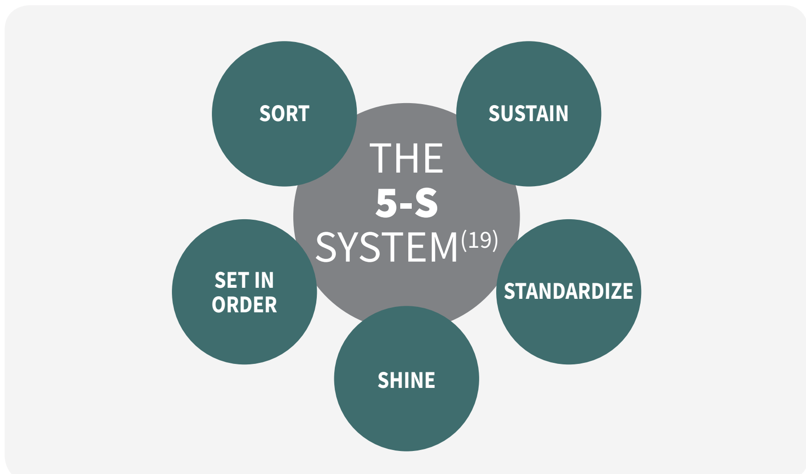


FIGURE 12: LEAN THINKING MODEL (SOURCE: SMITH AND LORD-2014)



Underpinning the re-organisation of the health service are:





The visible outputs of the facility re-organisation phase are:

1

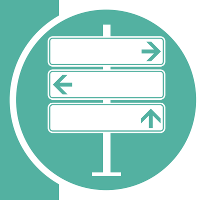
Administrative re-organisation

a. Appropriate signage for patients
b. Development of an appointment scheduling system for planned patient visits
c. Integration of clinical records into a single filing system with the appropriate stationary
d. Pre-appointment retrieval of patients' clinical records and pre-dispensing of medication for planned patient visits

2

Service re-organisation

a. Establishment of the four streams of care with designated waiting and service areas (explored on the following pages)
b. Designation of consultation room/s for attendance of scheduled and unscheduled patients
c. Addition of a designated vital sign monitoring station for patients in the respective service areas and/or the completion of vital signs within the consultation rooms
d. Pre-dispensing of medication including use of CCMDD services
e. Down referral of stable patients.



Service re-organisation into four streams of care

As discussed above, one of the key outputs of facility re-organisation, is the establishment of four streams of care, into which different services fall. These services are delivered in two different ways; either as planned appointments, or unplanned visits for patients without appointments as shown in figure 13 below.

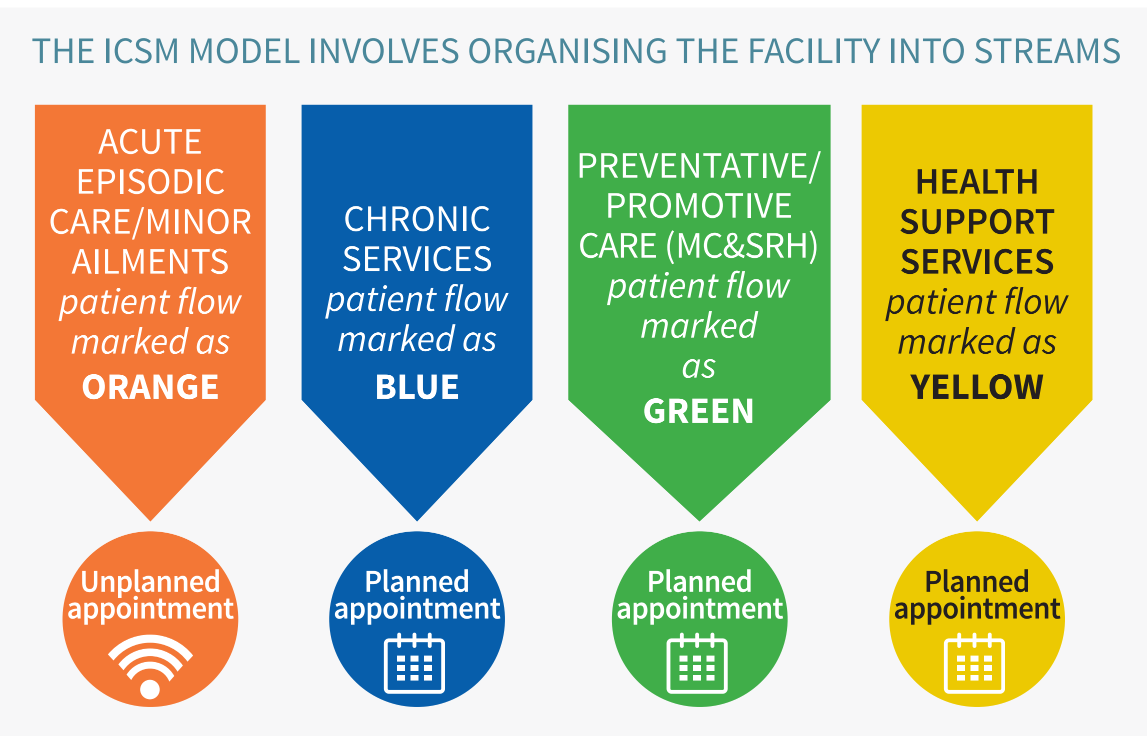


FIGURE 13: ORGANISATION OF SERVICES

All services provided should be ***adolescent and youth friendly***

Figure 14 shows the breakdown of services offered within the four streams of care. Also included is a short discription of each service. The patient flow is covered in more detail in the following section of this manual.

ACUTE EPISODIC CARE/ MINOR AILMENTS
Adults and children
Unknown/unplanned visit

- Episodic Care
- Medical Emergency
- Minor ailments
- Access to MC&SRH for the first time (confirmation of pregnancy and family planning)
- Referral from community screening
- Universal test and treat

CHRONIC CARE
Adults and children with chronic conditions
By appointment

- HIV
  - Wellness (Pre-ART)
  - ART Initiation
  - On ART
- TB
  - IPT
  - Drug sensitive
  - MDR (Down referred)
- NCDS
  - Diabetes
  - Hypertension
  - Cadio-vascular
  - Asthma/ Epilepsy
  - Other
- Mental Health

PREVENTIVE/ PROMOTIVE CARE (MC&SRH)
Well adults and well children
By appointment

- Maternal health
  - Antenatal
  - Post natal
- Reproductive health
  - TOP
  - Family planning
  - Sterilisation, MMC
- Child health
  - Well-baby clinic
  - Immunisation

HEALTH SUPPORT SERVICES
By appointment

- Oral health
- Physical therapy (physiotherapist/ occupational therapist)
- Podiatry
- Speech and hearing
- Mental health team (psychiatrist/ psychologist/mental health nurse)
- Eye care

ACUTE EPISODIC CARE/MINOR AILMENTS

Some patients may arrive at the PHC facility without appointments and will therefore be unknown, or unplanned. If they present as medical emergency patients or want to access MC&SRH for the first time or for universal test and treat or for episodic care or minor ailments, they will be categorised and seen as part of the Acute Episodic Care and Minor Ailments stream.

CHRONIC CARE PATIENT FOR REVIEW

Patients known to have a chronic or long term condition (either communicable or non-communicable) and who attend the facility for HIV, TB, NCDs or mental health reasons for planned appointments will be categorised and seen as part of the Chronic Care stream.

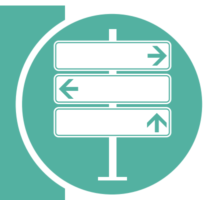
PREVENTATIVE/PROMOTIVE CARE

Patients visiting within the Preventive/ Promotive care (MCH &SRH) stream of health for either maternal health, child health (well-baby and immunisation) and; sexual reproductive health services will have an appointment (unless it is their first visit, in which case they will not be scheduled and will be seen in Acute episodic stream).

HEALTH SUPPORT VISITS

Health support stream patients visiting the facility for the first time will be unplanned, and therefore not have appointments and will be seen in Acute episodic stream and redirected as necessary and subsequent visits will usually be planned and by appointment .

FIGURE 14: STREAMS OF CARE



ACUTE EPISODIC CARE/MINOR AILMENTS

EMERGENCY ROOM

VITAL SIGN STATION ***ACUTE***

CONSULTATION ROOM

RECEPTION

PATIENT REGISTRATION

HIGH RISK PREGNANCY

FAMILY PLANNING/ ANC/IMMUNISATION ***FIRST VISIT***

FAMILY PLANNING/ ANC/IMMUNISATION ***SUBSEQUENT VISITS***

VITAL SIGN STATION ***CHRONIC***

CONSULTATION ROOM

VITAL SIGN STATION ***MC&SRH***

CONSULTATION ROOM

CHRONIC PATIENT ***UNSTABLE & STABLE FOR REVIEW***

MEDICATION ROOM/ PHARMACY

HEALTH SUPPORT SERVICES

ADHERENCE CLUBS/ CCMDD POINT

RECEPTION

APPOINTMENTS & EXIT

For non-chronic follow-up

FIGURE 15: PROCESS FLOW OF PATIENTS BASED ON SERVICE RE-ORGANISATION INTO STREAMS OF CARE

2. CLINICAL MANAGEMENT SUPPORT

The aim of the clinical management support component of the ICSM model is to improve the quality of clinical care provided to patients, through the application of evidence based guidelines and standardised tools.

The intended outcome is better clinical outcomes for patients as evidenced by decreased complications associated with the respective condition.

The National Department of Health has embarked on a process of developing clinical tools and evidence-based guidelines, in order to reduce the variation in the quality of service provided to clients. Each service provider should have a copy of these guidelines that are accessible during the patient's consultations either in hard copies or electronically.

ALL PHC CONSULTATION ROOMS	DOCTORS ROOM (ADDITIONAL)
Adult Primary Care (APC)	Standard Treatment Guidelines and Essential Medicine List for Hospitals - 2012 - Doctors consultation room
Standard Treatment Guidelines and Essential Medicine List for Primary Healthcare - 2014	Standard Treatment Guidelines and Essential Medicine List for Paediatrics – 2013- - Doctors consultation room
Integrated Management of Childhood Illness (2014)	Newborn Care Charts - Management of sick and small newborns in hospitals (Version 1, 2014)- - Doctors consultation room
Health Promotion for All	

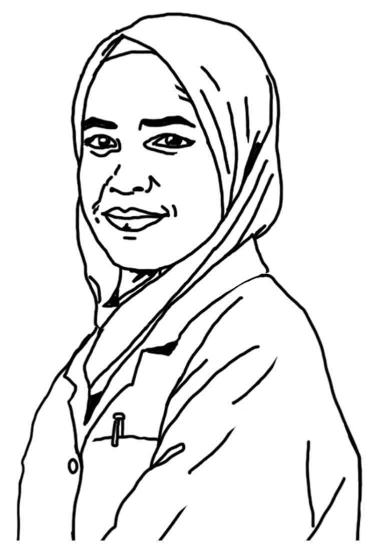
The following additional guidelines should be available at the facility:

Primary Healthcare Laboratory Handbook	National Guidelines for the Management of Tuberculoses in Children, 2013
National Consolidated Guidelines for the Prevention of Mother-to-Child Transmission of HIV and the Management of HIV in Children, Adolescents and Adults 2015	National Management of Drug-Resistant Tuberculosis. Policy Guidelines, 2013
National Tuberculosis Management Guidelines, 2014	Infection Prevention and Control Guidelines for TB, MDR-TB and XDR-TB

3. ‘ASSISTED’ SELF-MANAGEMENT

Self-management

This term refers to ‘the ability of the individual, in conjunction with family, community, and healthcare professionals, to manage symptoms, treatments, lifestyle changes, and psychosocial, cultural, and spiritual consequences of health conditions’. Optimal self-management entails the ability to monitor the illness and to develop and use cognitive, behavioural, and emotional strategies to maintain a satisfactory quality of life.



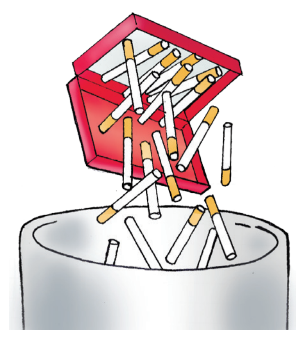
‘Assisted’ self-management

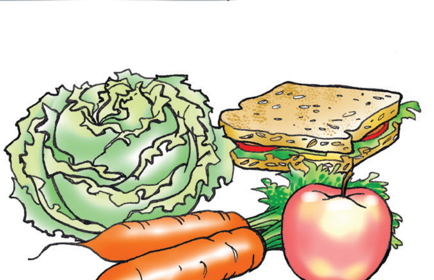
The majority of patients attending PHC facilities do not have the economic ability to monitor their disease conditions and are dependent on the health service. In addition, some services are only obtainable from contact with a health service facility. With the introduction of the Primary Healthcare Re-engineering framework, patients should be assisted in the management of their illnesses via ward based primary healthcare outreach teams (WBPHCOT), which provide health promotion, point of care testing, screening for complications, identification of high risk patients, adherence monitoring and may even serve as a medicine courier.

4. POPULATION HEALTH AWARENESS AND SCREENING

Primary prevention is most successful if conducted at a population level to increase awareness of the social determinants of health, and its direct impact on the development of chronic diseases. Tobacco use, unhealthy diet, physical inactivity, the excessive use of alcohol and the use of illicit drugs are common risk factors for the four priority NCDs.

- *Health awareness campaigns* should be organised to coincide with specific events within the health calendar.
- *Social marketing* should be used at sports and religious events to raise awareness around chronic conditions.
- *Screening services* should be provided during special events or at strategic points to identify asymptomatic patients or to identify at risk individuals and refer them appropriately.
- *Integrated school health teams* should conduct health education and awareness campaigns primarily at school level and provide screening services to assist with the early detection of chronic diseases and the appropriate referral of these high-risk patients.





Tobacco use, unhealthy diet, physical inactivity, the excessive use of alcohol and the use of illicit drugs are common risk factors for the four priority NCDs.

5. STRENGTHENING OF SYSTEMS AND SUPPORT STRUCTURES

Focusing on the service delivery component without adequately addressing health system components in healthcare affects the sustainability of ICSM implementation. The 'Ideal Clinic Manual' [20] provides a step-by-step guide on implementing Health System Strengthening activities.

SECTION THREE
PRE-IMPLEMENTATION PREPAREDNESS

PRE-IMPLEMENTATION → BRIEFING OF STAFF → SELECTION OF START DATE → FACILITY ICSM TEAM → COMMUNITY AWARENESS

This section of the manual provides a ***pictorial overview of the implementation process*** followed by the various steps required to prepare the facility for implementation of the model.

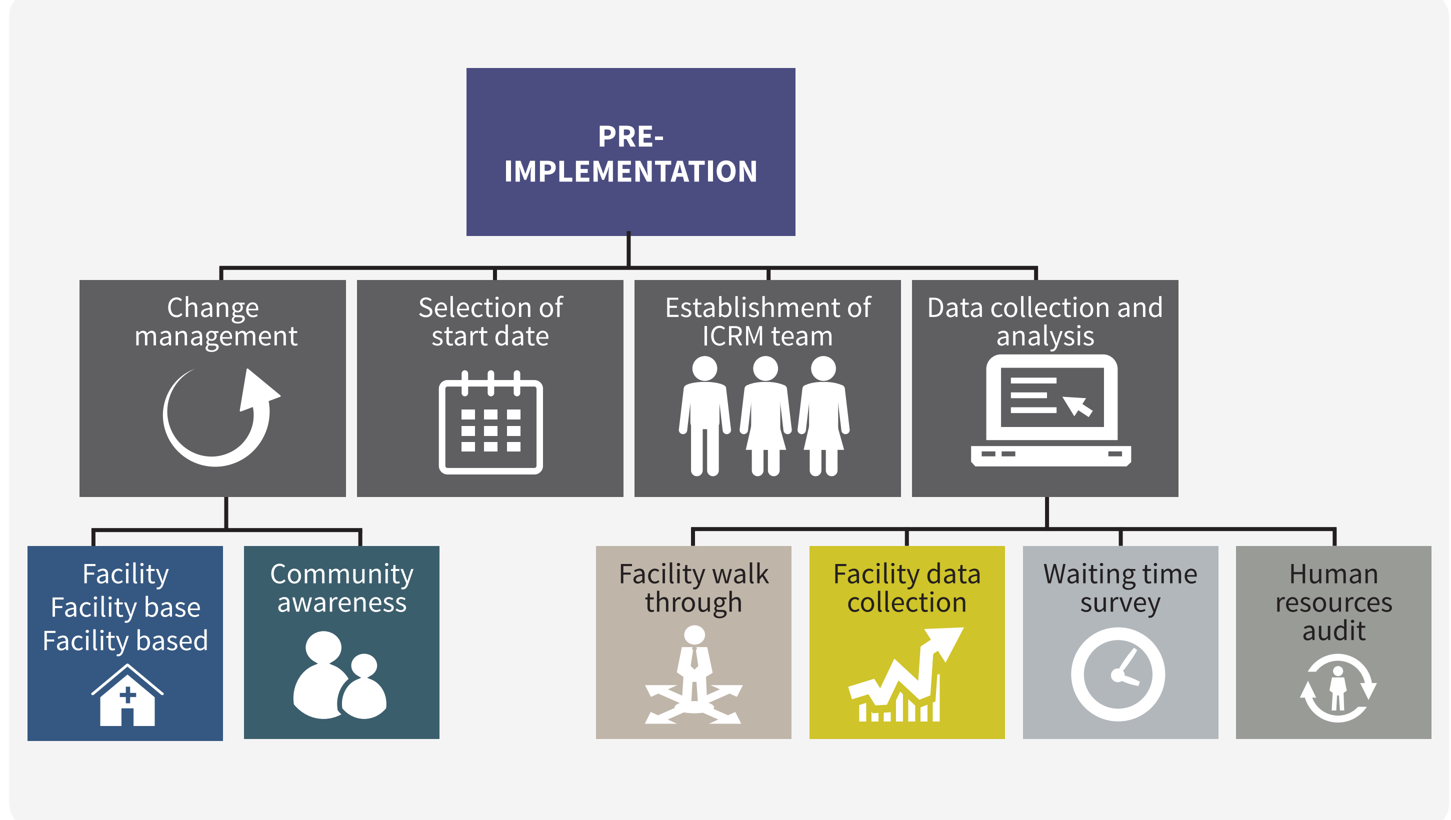
PRE-IMPLEMENTATION PREPAREDNESS	**PRE-IMPLEMENTATION**	BRIEFING OF STAFF	SELECTION OF START DATE	FACILITY ICSM TEAM	COMMUNITY AWARENESS	
	DATA COLLECTION	FACILITY WALK THROUGH	FACILITY DATA COLLECTION	WAITING TIME SURVEY	HUMAN RESOURCE TRAINING AUDIT	
	DATA ANALYSIS	NUMBER OF PATIENTS TO BE BOOKED DAILY	NUMBER OF CONSULTATION ROOMS PER STREAM	PROCESS FLOW	HUMAN RESOURCE TRAINING REQUIREMENTS	MANAGEMENT OF PATIENT RECORDS
HEALTH SERVICE RE-ORGANISATION	**ADMINISTRATIVE RE-ORGANISATION**	CREATING A SAFE ENVIRONMENT	SIGNAGE (INTERNAL AND EXTERNAL)	SINGLE ADMINISTRATIVE POINT	MANAGEMENT OF APPOINTMENTS	
	SERVICE RE-ORGANISATION	FOUR STREAMS OF CARE	APPOINTMENTS	FAST QUEUE	CCMDD OR PRE-DISPENSING	DOWN REFERRAL
	CLINICAL MANAGEMENT SUPPORT	CLINICAL GUIDELINES AND TOOLS	CLINCIAL STATIONERY & PATIENTS RECORDS	TRAINING OF STAFF	DR & DISTRICT CLINICAL SPECIALIST TEAM	
STRENGTHENING INDIVIDUAL AND POPULATION HEALTH	**'ASSISTED' SELF- MANAGEMENT**	COLLABORATION WITH WARD BASED OUTREACH TEAM	HOUSEHOLD VISITS	ADHERENCE CLUBS AND SUPPORT GROUPS		
	POPULATION HEALTH AWARENESS & SCREENING	HEALTH AWARENESS DAYS	UNIVERSAL TEST AND TREAT	INTEGRATED SCHOOL HEALTH TEAM	WARD BASED OUTREACH TEAMS	

MONITORING AND EVALUATION	WAITING TIME SURVEY	PATIENT EXPERIENCES SURVEY	CLINICAL AUDIT	PERFORMANCE INDICATORS	ADHERENCE TO APPOINTMENTS SURVEY	DASHBOARD

FIGURE 16: ICSM IMPLEMENTATION STEPS

Although this manual presents the implementation steps sequentially, the practical application of each of these steps may occur simultaneously.

1. PRE-IMPLEMENTATION



1.1. SELECTION OF THE STARTING DATE

- It is important to work backwards from a target.
- All the facilities identified to initiate the ICSM model should commence within the same period.
- All facilities should commence with implementation of the various components of the ICSM on the first Monday of a new month, 6 – 8 weeks after the training workshop.

1.2. ESTABLISHMENT OF A FACILITY ICRM TEAM – LARGE FACILITIES

The implementation of the Integrated Clinical Services component of the Ideal Clinic requires the collaboration of all disciplines within the facility. Therefore, at the outset, a multi-disciplinary team should be established in large facilities.

1.2.1. Team members

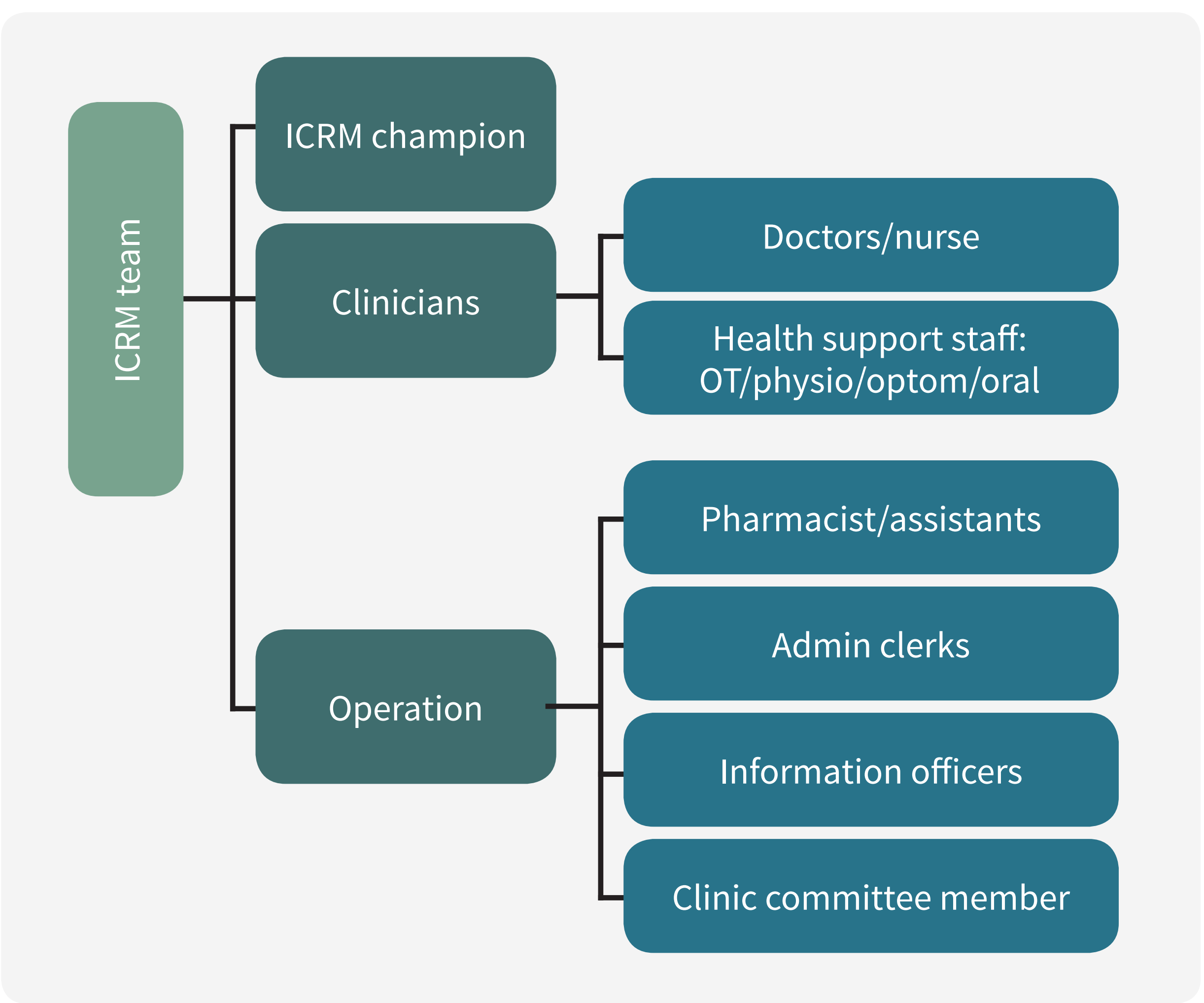


FIGURE 17: TEAM COMPOSITION FOR ICRM IMPLEMENTATION (LARGE FACILITIES)

1.2.2. ICRM champion

- The ICRM champion should be someone who advocates for ICSM at all times, and always acts as if the project is his or her 'baby'.
- The ICRM champion should be an individual of considerable importance in the clinic and should be diplomatic, have good communication skills, and be proactive; for example, ask about the status of a project rather than waiting to be told about the status of a project.

The coordinator and mentor for ICRM:

- Ensures stakeholder satisfaction and engagement from conception to completion.
- Addresses the various obstacles with respect to ICSM.
- Makes decisions or plans the steps that will make the project move forward.
- Liaises between the facility and the district management team and external stakeholders
- Maintains a harmonious relationship between the ICRM team and its stakeholders.
- Provides suggestions for solutions to the stakeholders who will then pick the best option.
- Communicates dates for the project's development and addresses concerns and issues, including possible changes of direction, or questions about the project's status and progress.

1.3. CHANGE MANAGEMENT

Rationale: ICSM requires a paradigm shift from the current service delivery approach, the active participation and buy-in from patients, communities and health service providers is needed. It is therefore important that patients and employees impacted by the change, are supported through their own transitions – from their own current state to their own future state, as created by the project or initiative.

The implementation of the ICDM model indicated that change management is important to adapt the attitudes of both staff and patients, and build consensus towards the implementation process.

The Prosci ADKAR model will be used as the change management tool([21]) (Figure 19). The model is a five-step process and each of these processes has to be completed for change to be successful (Table 3).

ADKAR MODEL

AWARENESS
- Of the need for change
- Of the nature of the change

DESIRE
- To support the change
- To participate and engage

KNOWLEDGE
- On how to change
- On how to implement new skills and behaviours

ABILITY
- To implement the change
- To demonstrate performance

REINFORCEMENT
- To sustain the change
- To build a culture and competence around change

FIGURE 18: PROSCI'S ADKAR MODEL (SOURCE: LINKED.COM)

Change management will be inculcated throughout the different phases of implementation.

TABLE 3: CHANGE MANAGEMENT ACTIVITIES EMBEDDED IN ICSM IMPLEMENTATION

CHANGE MANAGEMENT PROCESS	PATIENT PERSPECTIVE	HEALTH SERVICE PROVIDER PERSPECTIVE
Awareness	Briefing of clinic committees Media announcement by the district and local radio stations Meeting with communities and local leaders – community *imbizos* Briefing of patients attending the facility on a daily basis	Briefing of staff by the PHC supervisor and operational manager on the Ideal Clinic model and vision of National Department of Health
Desire	From patient perspective – improved waiting times and clinical care should be emphasised	All staff will have input in potential solutions Active involvement of quality innovation performance (QIP) team Mentoring and coaching
Knowledge	Patients will be provided with information on how to access the system	Onsite training will be provided on how to implement the QIP Outreach based training for clinical supportive component
Ability	Ward based outreach teams will provide supportive clinical management during household visits	Master trainers will be available for supportive supervision Direct involvement of ICRM team in coaching, mentoring or addressing challenges
Re-inforcement	Patients missing scheduled appointments will receive adherence counselling	Best practice will be shared Employees will be acknowledged Nomination for premiers' service excellence awards and National Department of Health awards

1.3.1. Raising awareness of the patients and staff about ICSM

Critical to the success of the implementation of ICSM, is change management from both the service provider and patient perspective. Patients will be sceptical of the changes if they are not provided with accurate information, and if the implications for their access to service providers and supply of medication are not adequately explained. Staff will feel threatened if their current comfort levels are challenged.

Briefing the staff

The district ICRM team, local area manager/PHC supervisor and District Clinical Specialist Teams (DCST) should provide a briefing to all the staff at the clinic about the Ideal Clinic and ICSM.

ICRM TEAM BRIEFING TO FACILITY STAFF

1. PHC re-engineering is the selected mechanism for overhauling the health system and improving patient outcomes.
2. The PHC re-engineering approach consists of three streams, namely; a ward based PHC outreach team for each electoral ward; district based clinical specialist teams with an initial focus on improving maternal and child health, and strengthening school health services.
3. An Ideal Clinic model has been launched to address the deficiencies within PHC clinics.
4. 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 health services to the community.
5. An Ideal Clinic cooperates with other government departments as well as with the private sector and nongovernmental organisations to address the social determinants of health.
6. The Ideal Clinic dashboard comprises 10 components, 32 sub-components and 273 indicators. At the same time a renewed focus has been placed on improved management for patients with long term conditions.
7. ICSM aims to assist facilities to achieve compliance with Domain 2 of the National Core Standards. The ICSM covers seven of the 32 Ideal clinic sub-components and 55 indicators.
8. Integrated Clinical Services adopts a ***supermarket approach*** in the organisation and delivery of services. The supermarket approach refers to the following:
    a. All services offered daily.
    b. Services are organised in different streams (like aisles in the supermarket) for ***planned*** and ***unplanned services***.
    c. Staff are clearly identifiable.
    d. Standard operating procedures and clinical guidelines guide the services offered.
    e. Customer satisfaction is the central goal of the services.

Integrated Clinical Services offered appropriately at the PHC centre has the potential to achieve benefits for the patient, facility and the health system at large.

From a patient perspective:

- Reducing number of facility visits – improve the patients social and economic productivity.
- Improved quality of care will be achieved – due to continuity of care being provided.

From a facility perspective:

- Improved working environment due to the reduction in the overflow of patients.
- Decreased patient waiting times.
- Improvement in quality of care provided – standardised documentation and care guided by protocols.

From a health system perspective:

- Improved coordination of care between clinics and community.
- Improved efficiency in services delivered.
- Decreased costs.
- Strengthening of up and down referral system.
- Improved capacity of human resources.

INFORMATION BOX: ICRM IMPLEMENTATION TEAM

The ICRM implementation team should comprise:

1. A ***team leader*** should have authority in the organisation.
    - They would be able to institute a suggested change and to overcome barriers that may inhibit its implementation.
    - They need to have authority over all of the areas affected by the change.
    - This person should also be authorised to allocate the time and resources the team needs to achieve its aim.
2. A ***technical/clinical expert*** knows the subject intimately and understands the processes of care.
3. An *ICRM improvement champion* must help to drive change, the provider should be a well-respected person who is influential among the medical staff, works well with management, and is open to change and new approaches. They would be best suited as the facility clinical trainer or as a 'go to person'.
4. An ***operations person*** should be integrally involved in current processes and be part of the team, because much of the innovative work involves designing new processes and streamlining old ones; doctors, nurses, support healthcare workers, administrative staff, information officers.

1.3.1.2 Raising awareness amongst patients and community

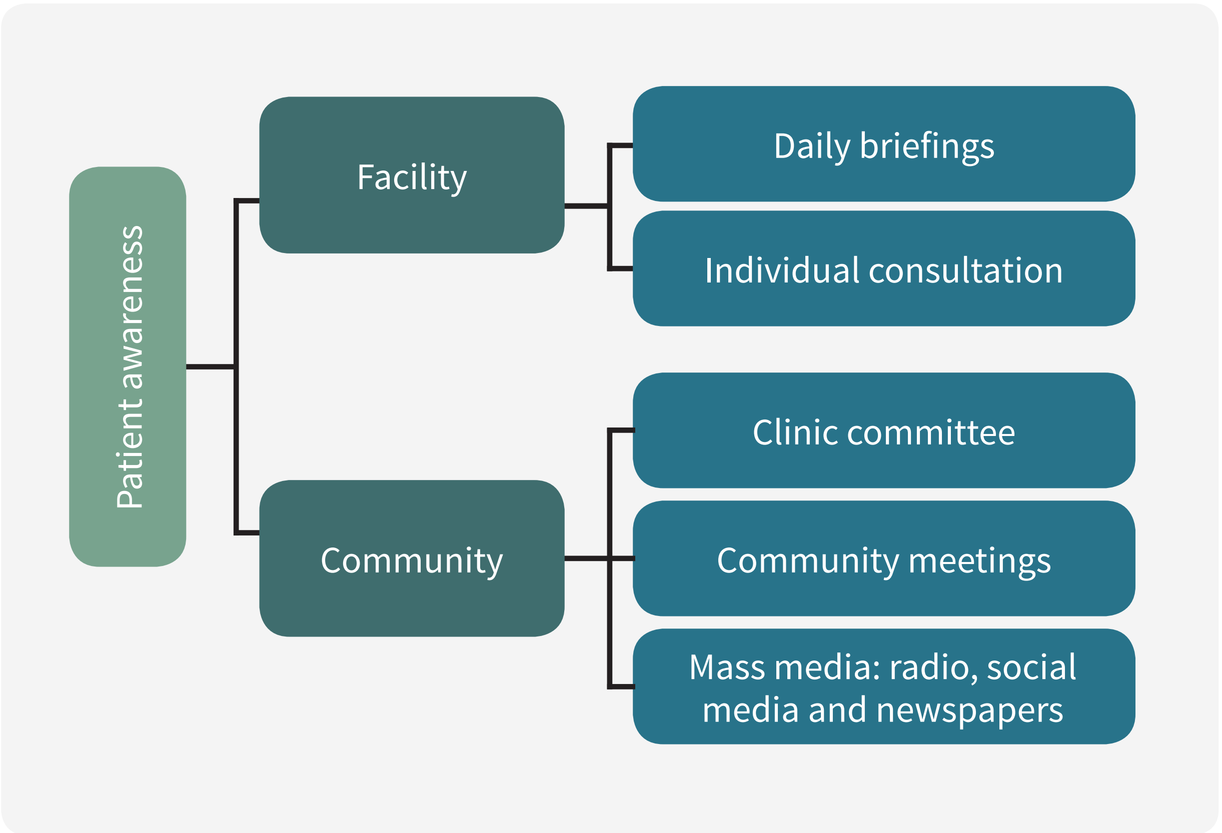


FIGURE 19: CHANGE MANAGEMENT OF ICSM (PATIENT PERSPECTIVE)

FACILITY (INDIVIDUAL LEVEL)

- Over a period of two months, the ICRM should provide general information to patients during morning health talks and prayer meetings.
- During the consultation process, service providers should inform patients of the impending changes.

COMMUNITY LEVEL

- The district manager should convene a meeting with all local councillors within the district and brief them about the Ideal Clinic and changes at facility level.
- The operational manager and the ICRM champion should convene a clinic committee meeting and provide the clinic committee with details regarding the impending changes at the facility and the anticipated implementation timeframes.
- The operational manager and/or ICRM champion should attend community *imbizo's* as well as obtain slots on local radio stations to explain the ICSM.

ICRM TEAM BRIEFING TO CLINIC COMMUNITY COMITTEES

1. An Ideal Clinic model has been launched to address the deficiencies within PHC clinics.
2. 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 health services to the community.
3. Integrated Clinical Services adopts a ***supermarket approach*** in the organisation and delivery of services. The supermarket approach refers to the following:
   - All services offered daily.
   - Services are organised in different streams (like aisles in the supermarket) for planned and unplanned services.
   - Staff are clearly identifiable.
   - Standard operating procedures and clinical guidelines guide the services offered.
   - Customer satisfaction is the central goal of the services.
4. Planned visits (appointments) will be implemented for chronic or maternal health patients.
5. Patients to contact the facility if they need to change an appointment.
6. If a patient misses the scheduled appointment they will be required to wait in the queue before they are consulted.
7. Stable chronic patients will be down referred to either the CCMDD unit or facility based medication collection or referral to adherence clubs.

ICSM BRIEFING FOR PATIENTS

- ICSM is intended to improve your experience with the services and also ensure you receive excellent quality of care using evidence based clinical guidelines.
- In order to provide you with the best service possible, we will be reorganising the facility into four streams of care: • acute episodic care • chronic care • maternal, women and child health • health support services.
- As a patient, you will either have a planned visit (in the case of repeat visits) or an unplanned visit for acute services or as a first time patient.
- You will receive an appointment for your planned visits and, where possible, all services will be offered to you at a single point of care. Alternatively, you will be referred internally for the additional service, but will receive it on the same day.
- If you have a long term condition, and you are stable with no signs of any complications, you will be assessed with respect to the feasibility of your receiving your medication via a designated service provider, adherence clubs or collecting medication from the clinic.
- You will receive six monthly prescriptions and an appointment for review after six months.
- The ward based outreach team will follow-up with respect to your adherence to medication and if you missed your follow-up appointments.
- If you miss your follow-up appointment and have not made alternative arrangements you will be treated as an unplanned visit and thereafter re-booked for the planned services.
- You will be provided an emergency number to contact, should you not be able to attend your scheduled appointment.

2. DATA COLLECTION

DATA COLLECTION → FACILITY WALK THROUGH → FACILITY DATA COLLECTION → WAITING TIME SURVEY → HUMAN RESOURCE TRAINING AUDIT

2.1. FACILITY WALK THROUGH

It is important to understand how patients navigate through the care delivery system. The best way to achieve this, is through process mapping. A process flow allows you to:

1

Understand what happens to the patient, where it happens and who is involved.

DISCUSSED IN THIS SECTION

2

Examine the process map to determine where there are problems.

DISCUSSED IN THE ANALYSIS AND REPORTING SECTION

2.1.1. Mapping out the facility

- The facility manager/ICRM champion or a designated member of the ICRM team should sketch out the layout of the facility (Figure 22).
    - This sketch should indicate entrances, exits, toilets, waiting areas and all service delivery areas available in the facility.
    - The sketch should also be labelled to depict which service is offered in the respective consultation rooms.
    - The sketch does not have to be exact or to scale.

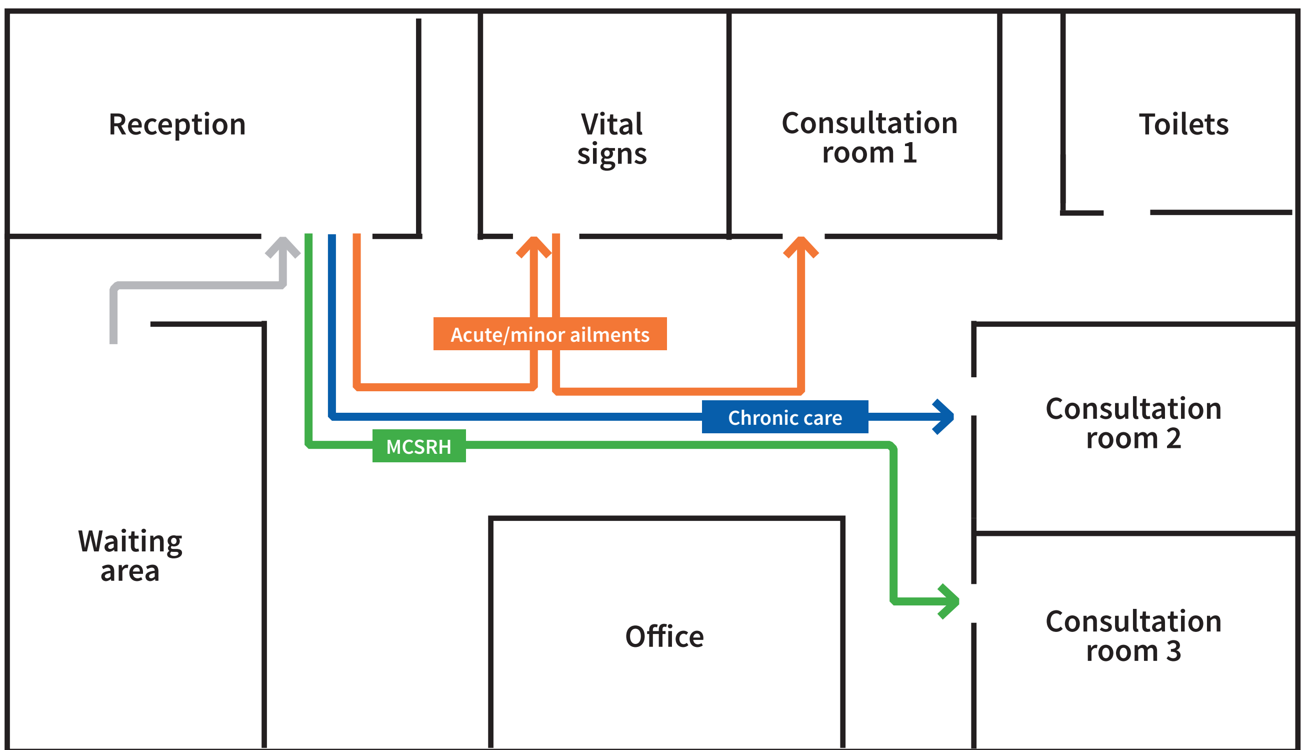


FIGURE 20: SKETCH PLAN FOR A SINGLE FACILITY

The ICRM team should plan a *facility walk through*.

The walk through does not need to be done on a single day but can be done per service.

The walk through needs to be done from a patient's perspective and should start from point of entry of the patient to the exit (main security gate) (Figure 23).

AS YOU WALK THROUGH THE FACILITY ADDRESS THE FOLLOWING POINTS

1. Identify points of entry and exit
2. Identify each step of the process
3. Describe the activities of the process
   a. What is the nature of the service?
   b. Are all services provided or are patients referred or transferred?
   c. Who provides the service?
   d. Determine availability of equipment
   e. Identify infection control practices
   f. Note medication storage and stock order levels
4. Identify possible areas of challenges from both patients and providers perspectives
5. Identify potential areas of waste

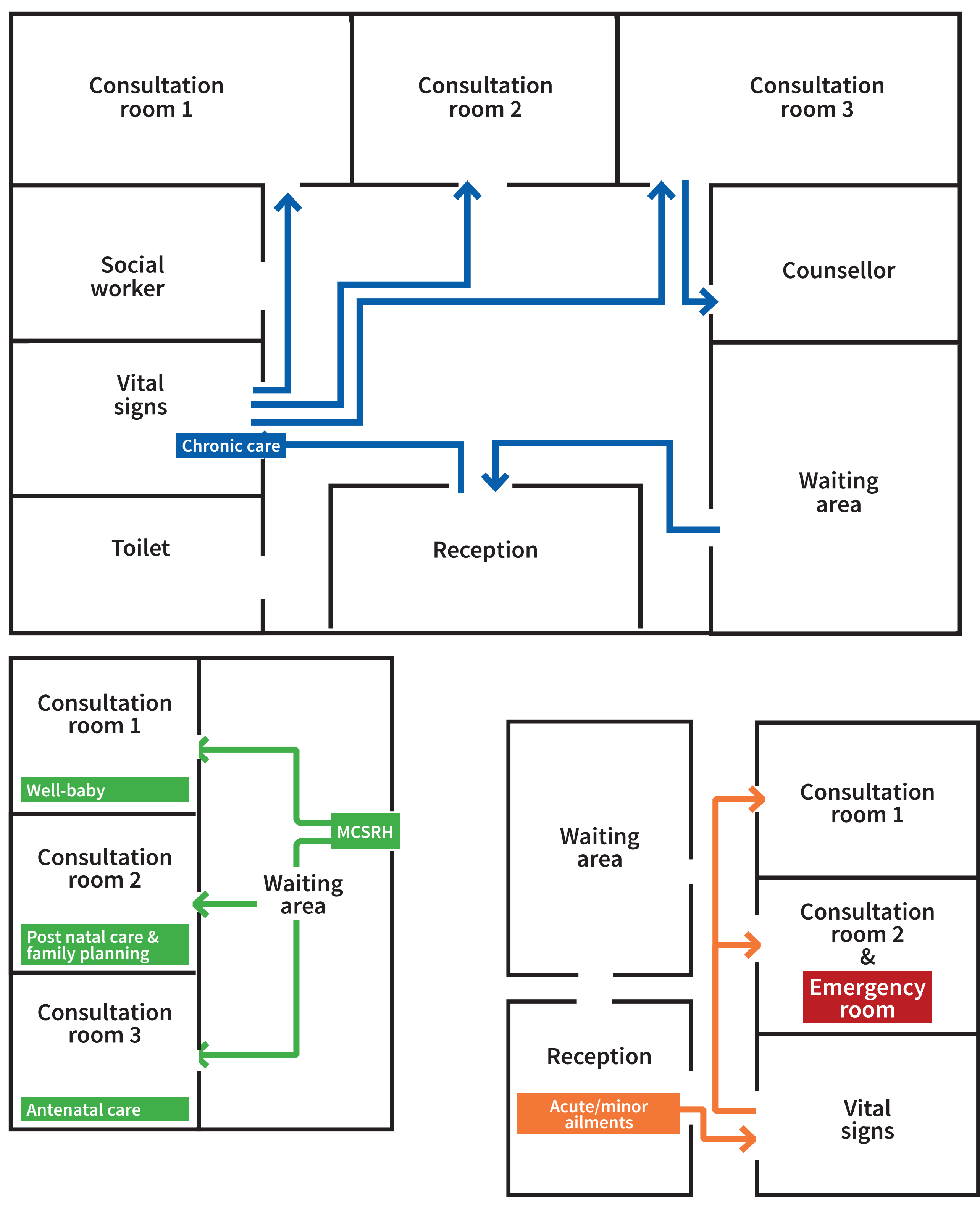


FIGURE 21: SKETCH PLAN FOR A MULTIPLE BUILDING FACILITY

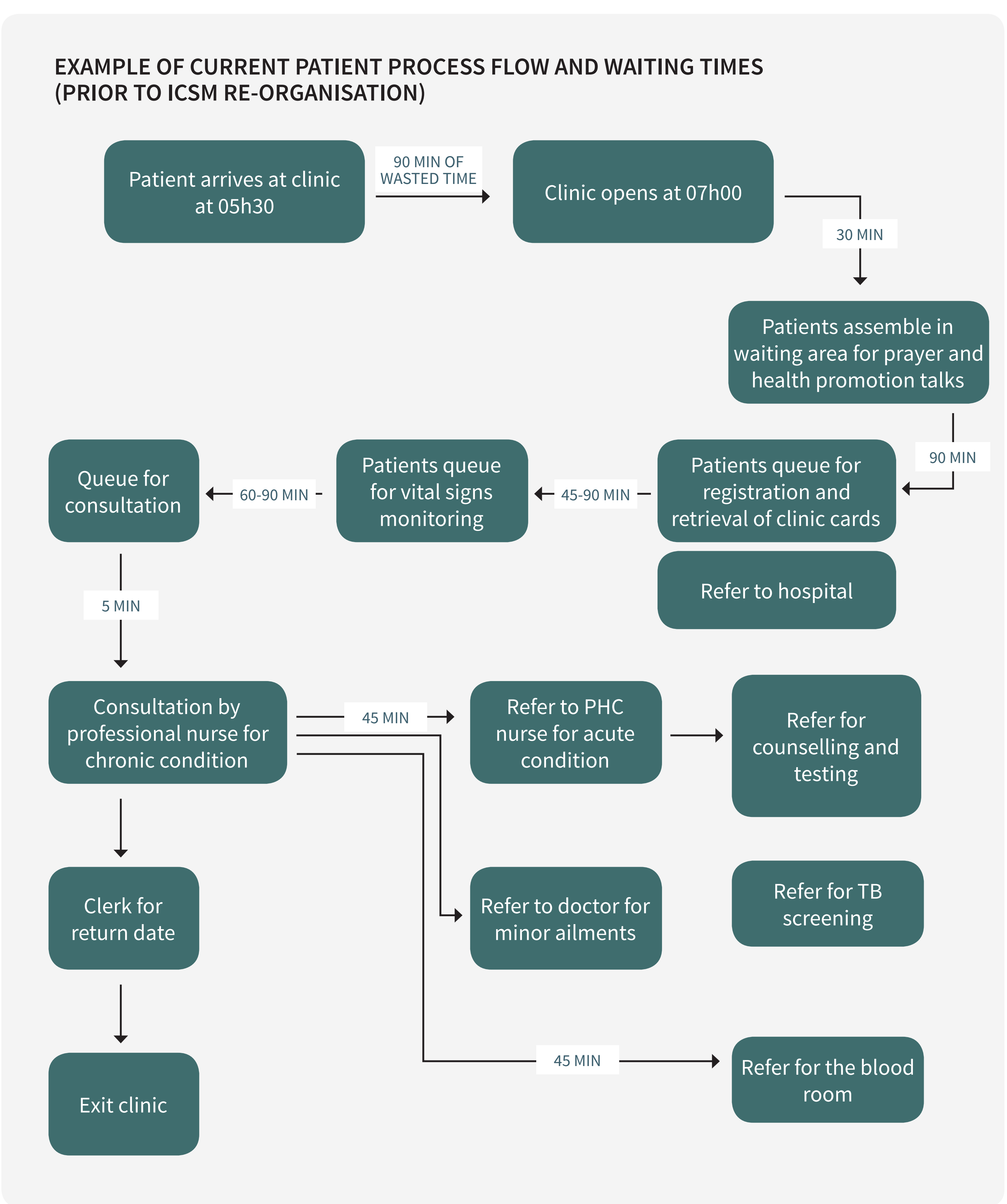


FIGURE 22: PATIENT PROCESS FLOW AND WAITING TIMES PRIOR TO ICSM RE-ORGANISATION

2.2. PATIENT WAITING TIME SURVEY

Patient waiting time is '*the time that the patient spends waiting for service/s in a facility*' per visit and is calculated from the time the patient enters the facility (*taking into consideration the official opening time of a facility*), to the time the patient leaves the facility.

2.2.1. Purpose of the waiting time survey

The purpose of the waiting time survey is to obtain a baseline measurement of the average total waiting time that patients spend in the clinic across all conditions and specifically for chronic conditions.

2.2.2. When will the waiting time survey be conducted?

Waiting time must be monitored quarterly. Select a day in the month of the quarter in which the waiting time will be monitored (pre-determined for specific clinic) e.g. second Monday of the month. *(Do not select the least busy day of a week!).*

Conducting the waiting time survey

i. The Patient Waiting Time Tool for monitoring outpatient visits should be utilised in order to measure the patient waiting and service times.
ii. The tool must be attached to the patient's file.
iii. Staff members at every service area must record time of the commencement of service and exit in the respective areas as outlined.
iv. Select the first 100 patients attending the facility, irrespective of diagnosis, on the day that the quarterly waiting time survey will be conducted. In small clinics continue the survey over two to three days until 100 patients have been surveyed.

Record the patient number
(e.g. 1 to 100)

PATIENT WAITING TIME TOOL

Mark the condition for which patient is attending with an 'X'

<table>
<tr><th colspan="2">ACUTE</th><th colspan="4">CHRONIC</th><th colspan="3">MOTHER AND CHILD</th></tr>
<tr><td rowspan="2">Minor Ailments</td><td>Children (IMCI)</td><td rowspan="3">HIV</td><td rowspan="3">TB</td><td rowspan="3">NCD</td><td rowspan="3">Mental health</td><td rowspan="3">Well-baby/
EPI</td><td rowspan="3">Family planning</td><td rowspan="3">ANC /PNC</td></tr>
<tr><td>Adult</td></tr>
<tr><td>24 hour Emergency Unit</td><td>24 hour MOU</td></tr>
</table>

[1] When the patient enters the door of the facility, the queue marshall (or designated staff member) should record the time.

Area	Enter time			
Time patient enters clinic [1]	Hours		Minutes	
Time patient registers at reception desk	Hours		Minutes	
Time patient is allocated patient record	Hours		Minutes	
Time patient completes vital signs	Hours		Minutes	
	Start time		End time	
1st consultation	Hours	Minutes	Hours	Minutes
2nd consultation (2 if referred)	Hours	Minutes	Hours	Minutes
3rd consultation (if referred)	Hours	Minutes	Hours	Minutes
The Pharmacy (if applicable)	Hours	Minutes	Hours	Minutes
Time patient departs clinic [3]	Hours		Minutes	

[2] If referred from doctor or nurse to lay counsellor or allied health services (rehabilitation, social worker, nutritionist, etc.).

[3] The last point of contact with service provision.

SOURCE: NATIONAL POLICY ON MANAGEMENT OF PATIENT WAITING TIMES, NOVEMBER 2015, NATIONAL DEPARTMENT OF HEALTH

2.3. FACILITY DATA COLLECTION

In order to match the services and further analyse the process flow, the following data for the past three months should be extracted from the registers or obtained from the *facility information officer*:

NB: NOT ALL THIS DATA IS AVAILABLE IN THE DHIS – USE PROXY ESTIMATES

FACILITY DATA TOOL

DATA ELEMENT	MONTH 1	MONTH 2	MONTH 3	TOTAL FOR 3 MONTHS	AVERAGE PER MONTH	AVERAGE PER DAY
Total headcount						
< 5 years						
> 5 years						
Acute Services						
Emergencies						
Minor ailments (adults)						
Children (IMCI)						
Chronic services						
HIV Pre-ART						
HIV on ART						
HIV stable						
TB initiation phase (1st 2 months)						
TB maintenance						
NCD						
Hypertension						
Diabetes						
Epilepsy						
Asthma/COPD						
Mental Health						
Other						
Preventive and promotive services						
ANC 1st booking						
ANC subsequent visits						
Well-baby						
Immunisation						
Family planning						
Male medical circumcision						
MOU						
Deliveries						
Health support services						
Occupational therapist						
Physiotherapist						
Speech and audiology						
Nutrition						
Social Services						
Eye Health						

2.4. HUMAN RESOURCE AND CAPACITY AUDIT

1. Obtain the following information from the operational manager or human resource managers at the district.

NO	CATEGORY OF STAFF	NUMBER EMPLOYED FULL TIME	NUMBER EMPLOYED SESSIONAL WORK	IF SESSIONAL- NO OF HOURS PER WEEK
1.	Medical practitioner – includes Medical officers, cCommunity service Dr and general practitioners			
2.	Operational manager			
3.	Professional nurses			
4.	Advanced mid-wife's			
4.	Enrolled/staff nurses			
5.	Enrolled nursing assistants			
6.	Pharmacist			
7.	Pharmacy assistants			
8.	Health Promoters			
9	Counsellors- VCT & adherence counsellors			
10.	TB tracers			
11.	Admin clerks			
12.	Facility information officer			
13.	Physiotherapist			
14.	Occupational therapist			
15.	Speech and audiologist			
16.	Dietician			
17.	Nutrition advisor			
18.	Optometrist			

TRAINING COMPLETED

NAME OF MEDICAL PRACTITIONER/ PROFESSIONAL NURSE	ADULT PRIMARY CARE (APC/PC101)	HIV- ART TRAINING	MENTAL HEALTH	INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI)	MANAGEMENT OF THE NEWBORN	ESSENTIAL MANAGEMENT OF OBSTETRIC EMERGENCIES	BASIC SURGICAL PROCEDURES	BASIC LIFE SUPPORT	ADVANCED LIFE SUPPORT

3. DATA ANALYSIS

DATA ANALYSIS → NUMBER OF PATIENTS TO BE BOOKED DAILY → NUMBER OF CONSULTATION ROOMS PER STREAM → PROCESS FLOW → HUMAN RESOURCE TRAINING REQUIREMENTS → MANAGEMENT OF PATIENT RECORDS

The QIP team should assemble and collate all the data. The data should then be analysed and action plans in line with the implementation of ICSM should be developed.

For each of the different components the QIP team should develop a modified A3 workbook.

3.1. DETERMINE THE PROJECTED DAILY WORKLOAD

DATA ELEMENT	MONTH 1	MONTH 2	MONTH 3	TOTAL FOR 3 MONTHS	AVERAGE PER MONTH	AVERAGE PER DAY
Total headcount						
<5 years						
>5 years						
Acute Services						
Emergencies						
Minor ailments (adults)						
Children (IMCI)						
Chronic Services						
HIV Pre-ART						
HIV on ART						
HIV stable						
TB initiation phase (1st 2 months)						
TB maintenance						
NCD						
Hypertension						
Diabetes						
Epilepsy						
Asthma/COPD						
Mental Health						
Other						
Preventive and Promotive Services						
ANC 1st booking						
ANC subsequent visits						
Well baby						
Immunisation						
Family planning						
Male medical circumcision						
MOU						
Deliveries						
Health support services						
Occupational therapist						
Physiotherapist						
Speech and audiology						
Nutrition						
Social Services						
Eye Health						

- For each of the services listed in the Facility Data Collection Tool – add the total of column 1, 2 and 3 to obtain a total for three months.
- Obtain the average number of patients consulted per month by dividing the total number for each condition by three.

A FIVE DAY WEEK – EIGHT HOUR A DAY FACILITY

- A 20 working day cycle will be used to determine the number of patients to be consulted to cater for pension days, public holidays as well as weekends.
- The booking is determined on a Monday – Friday
- Determine the number of patients to be consulted per diagnostic condition by taking the average and dividing it by 20.
- This will then provide the workload per day and projected number of patients to be scheduled
- For Health Support Services it is likely that this is an outreach service and possible five consultation days for the month

EXTENDED HOURS SERVICE- 6 DAYS A WEEK
(MONDAY TO FRIDAY- 07H00-19H00 & SATURDAY 07H00-13H00)

- A 22 working day cycle will be used to determine the number of patients to be consulted to cater for pension days, public holidays as well as weekends.
- Determine the number of patients to be consulted per diagnostic condition by taking the average and dividing it by 22.
- This will then provide the workload per day and projected number of patients to be scheduled
- For Health Support Services it is likely that this is an outreach service and possible five consultation days for the month and no weekend services

TWENTY FOUR HOUR EMERGENCY SERVICES/ MATERNITY UNIT AND EXTENDED HOUR SERVICES FOR NON-EMERGENCIES

- A 24 working day cycle will be used to determine the number of patients to be consulted to cater for pension days, public holidays as well as weekends.
- Determine the number of patients to be consulted per diagnostic condition by taking the average and dividing it by 24.
- This will then provide the workload per day and projected number of patients to be scheduled
- For Health Support Services it is likely that this is an outreach service and possible five consultation days for the month and no weekend services

PROJECTED WORKLOAD CALCULATION EXAMPLE FOR A FIVE DAYS SERVICE

DATA ELEMENT	MONTH 1	MONTH 2	MONTH 3	TOTAL FOR 3 MONTHS	AVERAGE PER MONTH	AVERAGE PER DAY
Total headcount	**9360**	**10002**	**10168**	**30069**	**11009**	**550,45**
< 5 years	1500	2250	1650	5400	1800	90
> 5 years	6500	7250	7100	20850	6950	348
Acute Services	**3150**	**3230**	**3050**	**9430**	**3143**	**157**
Emergencies	300	180	225	705	235	12
Minor ailments (Adults)	2350	2650	2200	7200	2400	120
Children (IMCI)	500	400	625	1525	508	25
Chronic Services	**5900**	**6455**	**6740**	**19095**	**6365**	**318**
HIV Pre-ART	600	700	750	2050	683	34
HIV on ART (new and not yet stable)	350	350	350	1050	350	18
HIV stable	1600	1800	2000	5400	1800	90
TB initiation phase (1st 2 months)	175	190	210	575	192	10
TB maintenance	300	320	320	940	313	16
NCD				**0**	**0**	**0**
Hypertension	1800	2000	2000	5800	1933	97
Diabetes	750	750	750	2250	750	38
Epilepsy	50	50	50	150	50	3
Asthma/COPD	140	150	155	445	148	7
Mental Health	80	90	100	270	90	5
Other	55	55	55	165	55	3
Preventive and Promotive Services	**945**	**1005**	**1035**	**2985**	**995**	**50**
ANC 1st booking	20	25	25	70	23	1
ANC subsequent visits	150	150	150	450	150	8
Well-baby	85	100	120	305	102	5
Immunisation	200	230	240	670	223	11
Family planning	450	450	450	1350	450	23
Male medical circumcision	40	50	50	140	47	2
MOU	**10**	**7**	**8**	**25**	**8**	**0**
Deliveries	10	7	8	25	8	0
Health support services	**300**	**310**	**370**	**1519**	**506**	**25**
Occupational therapist	25	30	35	176	59	3
Physiotherapist	65	75	85	248	83	4
Speech and audiology	45	55	65	240	80	4
Nutrition	35	40	40	180	60	3
Social Services	65	60	70	450	150	8
Eye Health	40	35	40	150	50	3
Oral Health	25	15	35	75	25	1

The hypothetical example above indicates that this facility on average consults about 550 patients per day.

3.2. NUMBER OF CONSULTATION ROOMS

- Using the nature of services and the facility infrastructure you will match number of consultation rooms to the services.
- Although it is ideal to use a ratio of 35 patients to 1 consultation room, this will not always be possible.
- Using the above hypothetical example and the ratio of 1: 35 patients, a total of 16 consultation rooms will be required. Certain services require their own consulting rooms however, and therefore, a total of 16 consultation rooms are required.
- Using the sketch map, allocate consultation rooms to the various services and consider the implications.
- Obtain input from staff and develop a consensus.

3.3. SCHEDULING OF SERVICE PROVIDERS AND PATIENTS

The above hypothetical example provides a general overview of the number of patients that can be scheduled for planned services and based on the allocation we can then plan the allocation of service providers for non-specialised services.

EXAMPLE OF STAFF SCHEDULING TO SERVICE PATIENTS

DATA ELEMENT	NUMBER TO BE SCHEDULED DAILY	ESTIMATED NUMBER OF PATIENTS TO BE BOOKED PER DAY	NUMBER OF SERVICE PROVIDERS TO BE ALLOCATED
Acute services	157	4	4
Chronic services	318	9	9
Preventive and promotive services	50	1	1
Health support services	25	Individualised	Individualised
Total headcount	**550**	**16**	**16**

3.4. PROCESS FLOW ANALYSIS

- Use your facility sketch plan and the current process flow map to analyse the current patient flow.
- Draw the lines representing the flow of the patients for a service from the various streams.
- At most facilities it will resemble a spaghetti map.

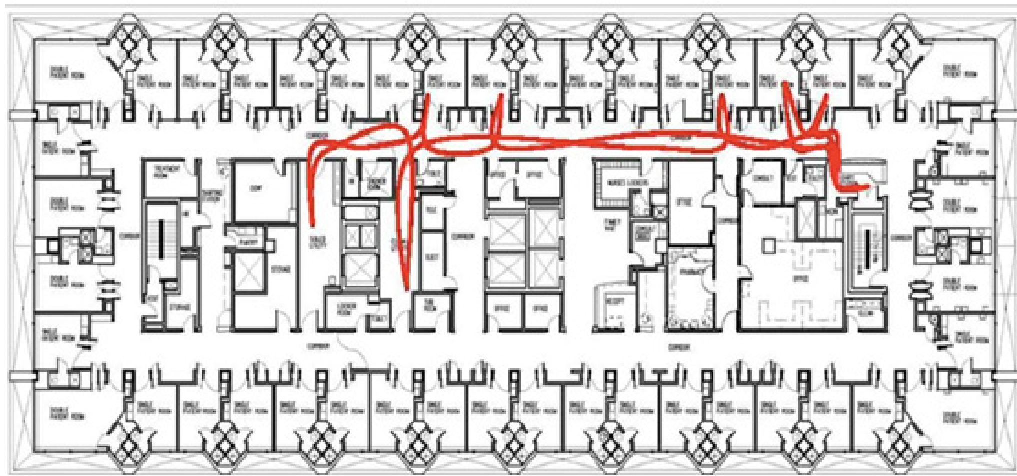


FIGURE 23: SPAGHETTI MAP

- Analyse the processes at the facility to identify potential sources of waste that affect the patient's experience.

There are three types of work:

1

Value add

When you are adding value to the patient/process.

E.G. PRESCRIBING MEDICATION, PROVIDING PHYSIOTHERAPY, REPORTING AN IMAGE

2

Necessary waste

This is when you are not adding value but it is a necessary step.

E.G. INCUBATION IN A MICROBIOLOGY LABORATORY, VETTING REQUESTS PRIOR TO RADIOLOGY EXAMINATION

3

Unnecessary waste

This is where you are not adding value and these steps could be removed.

E.G.SEARCHING FOR ITEMS, WAITING FOR CONSULTANTS OR MEDICATION, NOT HAVING THE RIGHT EQUIPMENT)

Identify potential areas of unnecessary waste:

SOURCE OF WASTE	DEFINITION	RESULT
Defect	All the errors that compromise quality, safety, cost and staff time	Repeated checking and Medication errors
Over production	dDoing too much, too soon or 'just in case'-	Results sent in both electronic and paper formats
Waiting	Time	Imbalance of process steps, which all take different times, or the batch sizes are different in each process step
Under utilised people	Not using appropriate skills for relevant task-	Highly skilled staff undertaking duties that do not reflect their skills
Transportation	Movement	Unnecessary movement of items and materials
Inventory	Work in progress and stock-	Overstocked medication
Motion	Unnecessary movement by people	Poor layout of wards/ surgeries/departments
Excess processing	Things we do that do not add any value to the process producing excess	Duplicate data entry

3.5. HUMAN RESOURCES TRAINING NEEDS

Identify the number of staff that will require further training either on an outreach basis or special training programmes.

TRAINING GAP			
NATURE OF TRAINING	MEDICAL PRACTITIONER/ DOCTORS	PROFESSIONAL NURSES	STAFF NURSES
Adult Primary Care (APC/PC101)			
HIV-ART training			
Mental health			
Integrated Management of Childhood Illness (IMCI)			
Management of the newborn			
Essential management of obstetric emergencies			
Basic surgical procedures			
Basic life support			
Advanced life support			

4. PLANNING THE IMPLEMENTATION

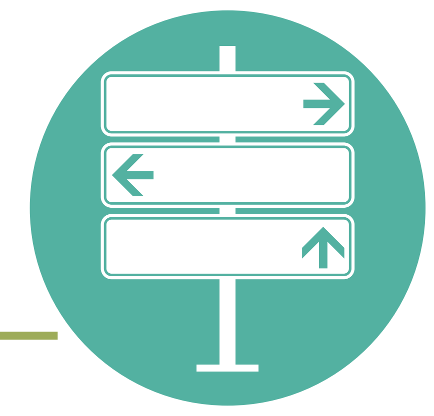
4.1. DEVELOPING AN ACTION PLAN

After raising patient and staff awareness and establishing a facility based ICRM team, a team meeting should be convened to develop an action plan for the planning phase of the ICSM implementation.

The action plan should address the following:

NO.	OBJECTIVE	ACTIVITY	TIMEFRAME	RESPONSIBILITY
1	To brief staff on ICSM implementation	Arrange a staff meeting with all category of employees		
2	To select date for the implementation of the ICSM	To conduct a staff meeting and determine the most suitable date for implementation of the ICSM		
3	To conduct patient awareness at facility level on ICSM implementation	Daily briefing for patients on ICSM		
4	To arrange community awareness for ICSM implementation	Meeting with clinic committees, imbizos, councillors and local radio stations		
5	To describe patient flow for the different services provided	To draw a line sketch of the facility depicting each consultation room and waiting area		
		To conduct a facility walk through mapping out the process for each category of patient		
6	To determine the demand for the various services offered at the clinic	To retrieve the patient data for the last quarter from the facility registers, DHIS, Tier.net and ETR.net		
7	To identify human resource capacity and training needs	To conduct a human resource training audit		
8	To review medicines storage, procurement, stock order levels	To determine the ability of the facility to cope with two month medication supply		
9	To review patient records in terms of the stationary and storage	To identify the infrastructure and stationary requirements for standardisation of clinical records		
10	To investigate the data collection process at the facility (tools and personnel)	To identify data collection, analysis and reporting procedure		
11	To determine the availability of the CCMDD services provider for the facility			
12	To identify the ward based outreach team and understand its service coverage and link with the clinic			

SECTION FOUR
HEALTH SERVICE RE-ORGANISATION



ADMINISTRATIVE RE-ORGANISATION | CREATING A SAFE ENVIRONMENT | SIGNAGE (INTERNAL AND EXTERNAL) | SINGLE ADMINISTRATIVE POINT | MANAGEMENT OF APPOINTMENTS

SERVICE RE-ORGANISATION | FOUR STREAMS OF CARE | APPOINTMENTS | FAST QUEUE | CCMDD OR PRE-DISPENSING | DOWN REFERRAL

This section provides a step-by-step guide on re-organising the facility.

1. CREATING A SAFE ENVIRONMENT

The 5S model is the basis for standardising work and is used to improve efficiency by eliminating waste, promoting flow, improving staff morale and most importantly improving safety[22].

When in doubt, move it out – RED TAG TECHNIQUE	A place for everything and everything in its place	Clean and inspect or inspect through cleaning	Make up the rules, follow and enforce them	Part of daily work and it becomes a habit

FIGURE 24: 5S EXPLANATION (SOURCE: HTTP://WWW.KAIZENWORLD.COM/WHAT-IS-5S.HTML)

SORT

'When in doubt, move it out!'

1. Remove everything from the defined area.
2. Only return what is necessary for the daily duties.
3. Discard any broken, unnecessary items – e.g. clutter, old equipment, old unused paperwork.
4. Move any items that you are unsure of into a holding bay for the team decision.
5. If shelving or cupboards are not used or required, remove them too – this will prevent unwanted items being stored there.
6. Items necessary to complete the job need to be 'set in order' 2S.

SET IN ORDER

'A place for everything and everything in its place.'

1. Give every item a location
   - Items used on a *regular/daily* basis need to be placed within arms length/accessible location:
   - Items used on a *weekly* basis should be stored on a shelf or in a cupboard in the work environment.
   - Items used on a *monthly*, quarterly or annual basis should be stored in an appropriate location –possibly outside the work area.
2. Mark off (with electrical tape or permanent marker) and label each location.

SHINE

'Lean means clean'

1. Clean the area – it should be easier to clean now you have removed the clutter and every item has a location.
2. Develop a plan where cleaning is incorporated into the daily routine.

STANDARDISE

1. Create a consistent approach for carrying out tasks and procedures.

SUSTAIN

'Sustain all gains through self discipline'

Make 5S become a way of life by:

1. Practicing and repeating the process.
2. Educating all staff.
3. Linking 5S directly to the day job.
4. Empowering staff t improve and maintain their workplace.

When staff take pride in their work and workplace it can lead to greater job satisfaction and higher productivity.

FIGURE 25: 5S ACTIVITIES (SOURCE: LORD AND SMITH-2014)

2. ADMINISTRATIVE RE-ORGANISATION

2.1. FILING AND CLINICAL RECORDS

SINGLE ADMINISTRATIVE POINT

1. All patients' records should be stored at a single administrative point.
2. Patients' records should be integrated and be available at the single administrative point for the patient.
3. All new patients and non-acute emergency patients should commence at the reception desk and be registered on the HPRS.
4. Chronic patients that are attending for a full consultation and who have not been registered on the health patient registration system (HPRS) should commence at the reception desk and be registered on the HPRS.
5. Patients returning to the facility for DOTS, scheduled appointments for family planning, immunisation, ANC and collection of chronic medication at the facility should proceed directly to the vital signs station of the various streams of care and receive their pre-retrieved clinical record.
6. The patient can then be registered on the HPRS by the administration clerk after the visit has been completed or in a batch when the clinical record is returned to the reception area but on the same day.
7. Alternatively, is that if the facility infrastructure and staffing levels allow, multiple service points should be made available at the reception desk creating an aisle for scheduled and unscheduled patients.
8. Scheduled patients clinical records should already be pre-retrieved and their entry on the HPRS should not be more than 20 seconds as claimed by the system implementers. These patients should then be directed to the streams of care.

INTEGRATION OF CLINICAL RECORDS

- Each patient should have a single file across his or her life span.
- The facility should have a single system for filing and storing patients' clinical records.
- The records should not be stored per diagnostic condition but rather by the patient surname, date of birth or address.
- In order to identify a chronic patient's record, a colour-coded sticker should be affixed to the front cover.

THE FILE NUMBER SHOULD CONTAIN

1. Date of Birth, expressed as yyyy/mm/dd
2. First 3 letters of surname

e.g. Thandi Mmamabolo, born 2 8 June 1973

Should be rendered as:

1973/07/28MMA

2.1.1. Contents of the clinical record

The National Department of Health has embarked on a process to standardise patient clinical records. The clinical records are designed for a five year period. The contents of the clinical records are as follows:

CHILDREN CLINICAL RECORD	ADULT MALE	ADULT FEMALE
Demographic details	Demographic details	Demographic details
Subsequent changes to demographics details	Subsequent changes to demographics detail	Subsequent changes to demographics detail
Patient profile – first visit	Patient profile – first visit	Patient profile – first visit
Annual review	Annual review	Annual review
Immunisations	ART initiation	ART initiation
Development screening	Clinical management	Clinical management
Growth chart – girl	Oral healthcare	Basic antenatal care assessment
Growth chart – boy	Rehabilitation service	Oral healthcare
Well child visit	Laboratory test results	Rehabilitation service
ART initiation	Prescription	Laboratory test results
Clinical management birth to 5 years	TB adherence	Prescription
Clinical management 6 to 15 years	Consent for HIV and other testing	TB adherence
Oral healthcare	Consent for HIV and other testing	Consent for HIV and other testing
Rehabilitation	Pockets for laboratory results and referrals	Consent for HIV and other testing
Laboratory test results		Pockets for laboratory results and referrals
Prescription		
TB adherence		
Consent for HIV and other testing		

NO REQUIREMENT FOR ADDITIONAL STATIONARY – ONLY MAY NEED CONTINUATION SHEETS TO WRITE ADDITIONAL CLINICAL NOTES

GUIDELINES ON COMPLETING THE RECORD WILL BE AVAILABLE FROM DEPARTMENT OF HEALTH

ONCE A FEMALE ***ADOLESCENT*** IS PREGNANT AN ***ADULT*** FEMALE RECORD SHOULD BE OPENED

2.1.2. 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.

2.2. 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, wo to three slots should be left blank for patients that missed scheduled appointments but returned within the 96 hour grace period.

Frail, elderly and high risk clients should be given priority.

Adolescents and youth should be scheduled after school hours.

PATIENT SCHEDULING TOOL

Department of health Patient Details

Complete the consultation room number, day of the week and day

Consultation room: 5

Day of the week (circle): Mon | Tues | Wed | Thur | Fri | Sat

Date: 01/11/2016

No.	File number	Full name and surname of patient	Comment	File retrieved		Attended appointment		Record returned	
				Y	**N**	**Y**	**N**	**Y**	**N**
07.30-10.00									
1	2463013579	Mary Saints	CCMPP	**Y**	N	Y	N	**Y**	N
2.				Y	N	Y	N	Y	N
3.					N	Y	N	Y	N
4.					N	Y	N	Y	N
5.					N	Y	N		N
6.					N	Y	N		
7.					N	Y	N		
8.					N	Y	N		
9.				Y	N	Y	N		
10.	125456789	James Tse	FU				N		
****Tea time = 10.00-10									
11.								Y	N
12.								Y	N
13.								Y	N
14.								Y	N
15.								Y	N
16.	2345678901	Polly Jacaranda	LR				**N**	Y	**N**
17.				Y	N	Y	N	Y	N
18.				Y	N	Y	N	Y	N
19.				Y	N	Y	N	Y	N
20.				Y	N	Y		Y	N
Lunch time = 12.45-13.30 * 13.30 - 18.00									
21.				Y	N	Y			N
22.				Y	N	Y			N
23.				Y	N	Y			N
24.				Y	N	Y	N	Y	N
25.				Y	N	Y	N	Y	N
26.									
27.									
28.									
29.									
30.									
Unbooked patients … ts who present within 5 working days									
31.	5678901234	Zethewbe Ndlovo							
32.									
33.									
34.									
35.									

Complete patient file number here. The unique patient record number generated by HPRS is 10 digits long

Indicate if the patient's file was pre-retrieved. This should be done 48-72 hours before the scheduled appointment

Indicate if the patient's record was returned to reception for filing.

Indicate reason for appointment, eg. laboratory results (LR), referred for doctor consultation (DR), Collection of meds only (CCMDD), regular follow-up (FU), 6-monthly follow-up (6mth FU). This is done at the time that the appointment is being made.

Complete patient's full name and surname

Indicate if the patient attended the appointment

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 files - records retrieved:		Total number of files - 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: eg.

1. Patient defaulted – referred for tracing. You can add address and health tracer's name
2. Requiring a full clinical examination (6 month visit)
3. Repeat visit (chronic, immunisation, family planning)
4. Consultation by doctor
5. Collection of medication – CCMDD facility based

Attended: The last column should reflect if the patient attended (✓) of if the patient defaulted (x)

WHAT IS THE PROCEDURE WHEN A PATIENT MISSES THEIR SCHEDULED APPOINTMENT DATE?

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?

1. Chronic stable patients for medicines collection should be scheduled between 07h30 and 08h30 or between 15h00 and 16h00.
2. Well-baby clinic, immunisation, post natal visits and follow-up antenatal visits should be scheduled for the 1st 2 hours (8h30-10h30).
3. Patients with acute episodic illness, antenatal first visits and patients for chronic prescription six month review should be scheduled between 10h30 and 14h00.
4. Family planning and other preventive services should be offered between 14h30 and 16h00.
5. Emergencies should be consulted at anytime.

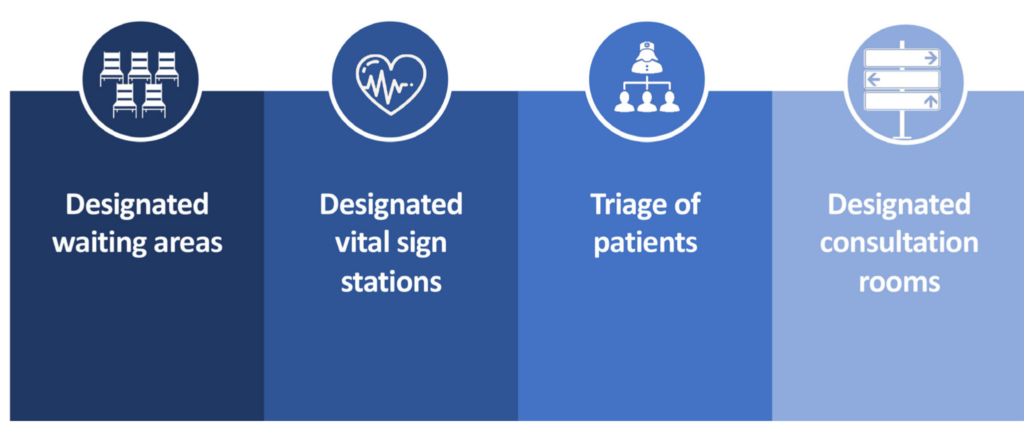
Ensure co-ordination of appointments, for example, a mother coming for a chronic appointment but also needing her baby to be immunised, should be given one appointment.

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.



2.3. FACILITY PROCESS FLOW

2.3.1. Additional vital sign stations

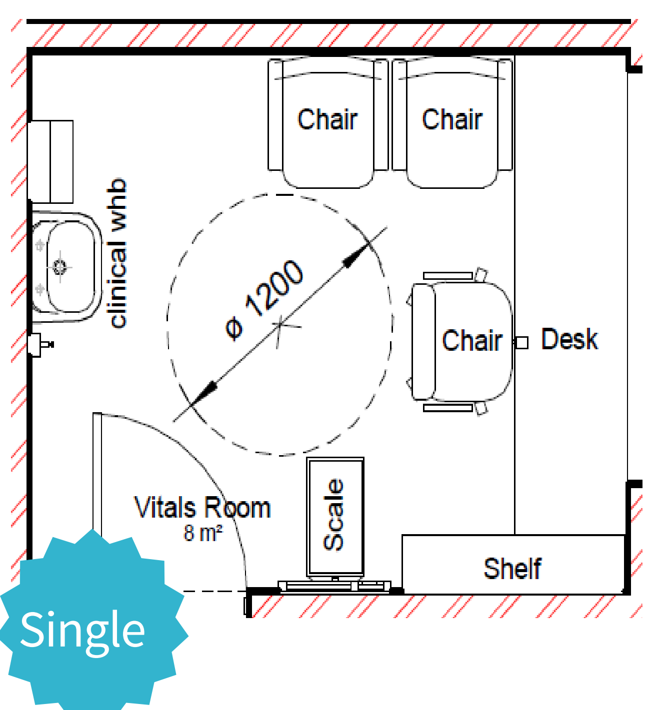
The vital signs station is a bottleneck in many facilities. To facilitate the patient flow, an additional vital signs monitoring station should be established for each separate stream of care where feasible.

These vital signs stations should be conveniently located between the patient waiting area and consultation room.

REQUIREMENTS FOR EACH VITAL SIGN STATION

a. Desk
b. 2 chairs
c. Medical record stationary
d. Body mass index scale
e. Sphygmomanometer
f. Blood glucometer
g. Urine dipsticks
h. Thermometer
i. Stethoscope

At facilities where less than 30 patients are booked for a stream of care and there is sufficient equipment available, vital signs should be monitored in the consultation room.



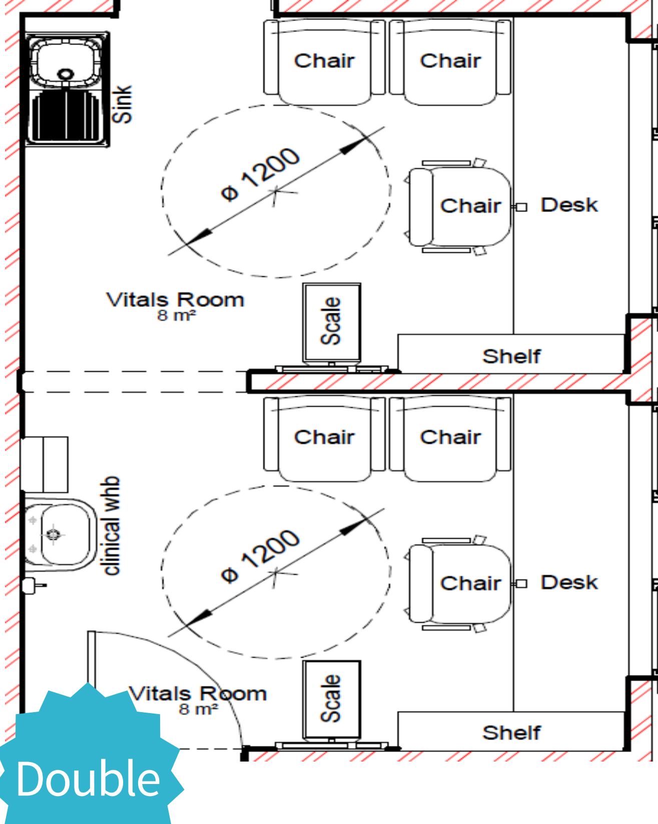


FIGURE 26: LAY OUT OF SINGLE AND DOUBLE VITAL SIGNS STATION

2.3.2. Designation of consultation rooms

- Allocate consultation rooms that are adjacent to each other for each stream of care, if more than one consultation room is to be used.
- Ensure that there is no cross flow between patients.
- The patients should be able to exit after consultation easily, without having to re-enter the main clinic area if the facility infrastructure allows this.
- Each consultation room should be well ventilated.

KEY REQUIREMENTS IN CONSULTATION ROOMS

- Hand washing basin in the room or adjacent to it
- Desk with a lock up drawer
- Three chairs
- Appropriate medical consulting bed
- Mobile examination lamp
- Lock up cabinet for storage of patient medication
- Three colour coded waste containers
- Basic diagnostic set – ophthalmoscope and otoscope
- Thermometer
- Stethoscope
- Blood glucometer
- Sphygmomanometer
- Peak flow meter
- Urine dipsticks

CLINICAL STATIONARY IN CONSULTATION ROOM (MINIMUM** PLUS ADDITIONAL BASED ON DESIGNATION)

- Clinical Guidelines (APC/PC101)**
- Essential Medicine List and Standard Treatment Guidelines for PHC**
- Health Promotion Compendium**
- Essential Laboratory List and Requisition forms**
- Prescription forms**
- Transfer forms**
- Continuation sheets**
- Reporting forms**
- Other clinical guidelines as per designation of consultation room
- Necessary posters and information material

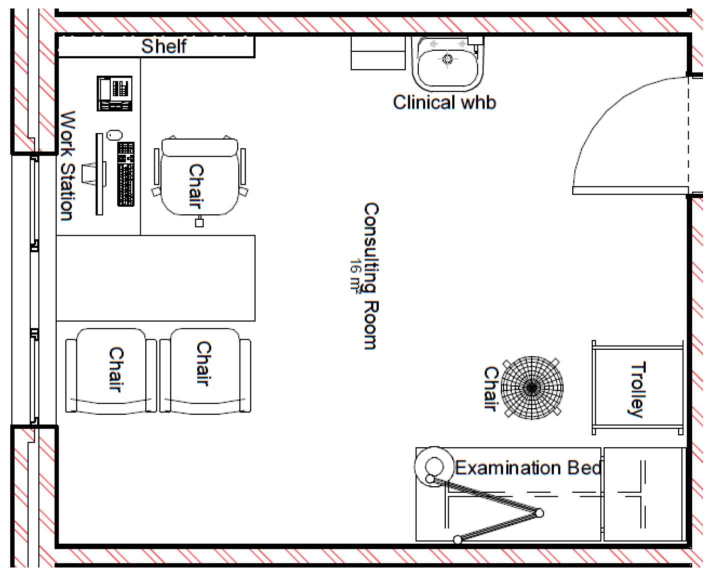


FIGURE 27: LAYOUT FOR A CONSULTATION ROOM

PASSAGE AND WATING AREA FOR CHRONIC PATIENTS

LABOUR WARD AND COUNSELLING ROOM

SLUICE ROOM

ENTRANCE AND EXIT

CHRONIC CONSULTING ROOM (INCLUDING ART INITIATION

CHRONIC VITAL SIGN STATION

DRY STORAGE

WAITING AREA FOR MATERNAL AND CHILD HEALTH

CHRONIC CONSULTING ROOM

MOTHER AND CHILD HEALTH SERVICES

TOILETS

PASSAGE AND WAITING AREA

MEDICINES STORAGE ROOM

RECEPTION: MINOR ILLNESS & MATERNAL HEALTH & PREVENTIVE SERVICES

CONSULTING ROOM 1 - MINOR AILMENTS

ENTRANCE AND EXIT

WAITING AREA - FOR MINOR AILMENTS PATIENTS

VITAL SIGN STATION FOR MINOR AILMENTS PATIENTS

2.4. PRE-DISPENSING OF PATIENT MEDICATION AND MEDICAL SUPPLIES

2.4.1. Issuing of medication to primary care consultation room

- Orders from consultation rooms should be done regularly depending on facility needs.
- Daily orders can be submitted for facilities with insufficient cupboard space.
- Facilities rendering a 24 hour service can consider ordering twice daily.
- One consultation room order form should be used for each individual consultation room.
- Professional nurse to check for stock on hand for each item in the consultation room medicine cupboard and calculate the quantity to order, by subtracting the on-hand quantity from the maximum level.
- Repeat for each item to order from the medicine room.
- Submit order form to the person responsible for the medicine room according to the schedule.
- Stock to be issued from the medicine room and stock card in medicine room to be completed.
- Enter quantity issued from medicine storeroom on the consultation room order form.
- Stock should be collected from the medicine room.
- Order form to be signed as proof of receipt of stock for consultation room.
- File the signed order form according to consultation room for record purposes.
- Professional nurse to pack received stock into the consultation room cupboard *immediately*, according to FIFO/FEFO principles.
- Pack stock in brazier bins as labeled according to therapeutic categories. See below:

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**

2.4.2. Facility medicine collection

The pharmacy assistant, where available, or professional nurse allocated to the various services, should pre-dispense the medication for the patients on the appointment schedule.

Chronic medication

- Chronic medication should be pre-packed in a brown bag or clear 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 not be closed so the medication can be validated on dispensing to the patient.

  Storage

  - Once the medication has been pre-dispensed, depending on the allocation of the patient, the medication should be stored neatly in boxes/trays in alphabetical order.
  - The medication should then be placed in the medication cupboard according to alphabetical order, in the respective consultation rooms that the patient will be allocated to.

Mother and children

- Oral contraceptive agents should also be pre-packed in a brown bag or clear opaque plastic bag where available.
- Single dose injectable should be pre-dispensed according to the number of patients.
- For antenatal patients the relevant supplements should be pre-dispensed and stored per patient.
- Immunisation vials should be quantified and only the required amounts should be removed from the refrigerator and transferred to the cooler box on morning of the patient attending.

2.4.3. Central chronic medicine distribution and dispensing

The following standard operating procedure will be applicable.

NOTES/SAFETY WARNINGS
a. In the case where the PDoH health facility acts as a PuP, the health facility will have the responsibility for all PuP prodedures/functions. In this instance, medicine parcels must be issued to the patient (or nominated person) by a personnel member of the health PDoH facility.
b. Patients should not pick up facility files.
c. Patients should not go for observation or go to clinician unless indicated.
d. Patients are requested to pick up the medicine parcels in the allocated area for internal CCMDD PuP.
e. Patients should be well informed about the process of the internal PuP by the health facility.
f. Patients without a valid ID or passport number (or any other unique identifier as may be approved by the PDoH) may not be registered with the CCMDD programme and may not register to collect their medicine at an alternate PuP.

NO	PROCEDURE	RESPONSIBILITY
Issuing medicine parcels to patients		
1	The person issuing the medicine parcel to the patient must: g) Check the identity document/passport (or other unique identifier e.g. facility number as approved by PDoH) of the patient. (A nominated person collecting on behalf of the patient must produce his/her ID document/ passport). Patient/nominee must also bring their medicine collection card h) Check the delivery manifest to confirm that the medicine parcel has been received (where scanning process is being used it can be checked on system) i) Retrieve the medicine parcel and check label to ensure that the correct parcel is being issued to the correct patient j) Issue the parcel and scan the parcel out (where scanner is available) and ask the patient/nominated person to sign the manifest (proof of receipt by patient) k) Enter issue date on medicine collection card so that PDoH health facility can determine if the patient was compliant in collecting medicines from PuP when they return for clinical review and a new script	Pick-up Point
2	Request patient to return to their originating PDoH health facility if he/she complains of problems with medication and is found to be unstable or unwell	Pick-up Point
Medicine parcel not delivered on time by CCMDD service provider		
1	Notify the CCMDD service provider if the medicine parcel has not been delivered by the date that patient rightly presents for collection and obtain information on when the parcel will be delivered and log a call on the toll free number	Pick-up Point
2	Refer the patient back to the PDoH originating health facility if patient claims to have insufficient medicines to continue with treatment	Pick-up Point
3	Inform the patient when their medicine parcel has been delivered to the pick-up point for collection	CCMDD service provider

NO	PROCEDURE	RESPONSIBILITY
Medication error reporting		
1	Inform patient to report any medication errors noted to the CCMDD service provider on the CCMDD call centre number	Pick-up Point
2	Record and report suspected medication errors noted and log a call on the toll free number	Pick-up Point
Handling late collection (medicines not collected within 48 hours) by patients		
1	Inform CCMDD service provider of all patients who did not collect their medicines within 48 hours (2 days after) the scheduled date of collection	Pick-up Point
2	Re-contact patients (reminder call/sms) to collect medicine when notified by PuP	CCMDD service provider
3	Inform the PDoH originating health facility to do a follow-up of the patient (in the case of external PuP)	CCMDD service provider
4	Initiate patient tracing using available tracing mechanism	PDoH health facility
5	Continue to issue medicine parcels to patients who present within 14 days of their scheduled date of collection	Pick-up Point
Patient does not collect medicines within 14 days		
1	After 14 days of collection date record number of uncollected parcels on the manifest. Inform CCMDD service provider to uplift parcels	Pick-up Point
2	Refer patients who present after 14 days back to the PDoH originating health facility	Pick-up Point
Issue records		
1	Ensure that all patients/nominated persons to whom medicine parcels have been issued sign the delivery manifest	Pick-up Point
2	Maintain a record of patients whom have collected/not collected and inform the CCMDD service provider 48 hours after a collection date and again after 14 days	Pick-up Point
3	Retain original patient signed manifest	Pick-up Point

3. SERVICE RE-ORGANISATION

This section highlights the possible pathways that a patient attending the PHC clinic for acute episodic illness, chronic diseases, maternal, women and child health services and health support services could be channelled through.

3.1. ACUTE EPISODIC CARE/MINOR AILMENTS (ADULTS OR SICK CHILDREN) STREAM OF CARE

- Patients attending with acute illnesses are usually unplanned, but visits should be planned for patients who have follow-up or review visits.
- Patients attending for acute illnesses could be non-emergency conditions or patients with illnesses that could be classified as emergencies.
- Patients with acute illnesses could potentially be either infectious or non-infectious.

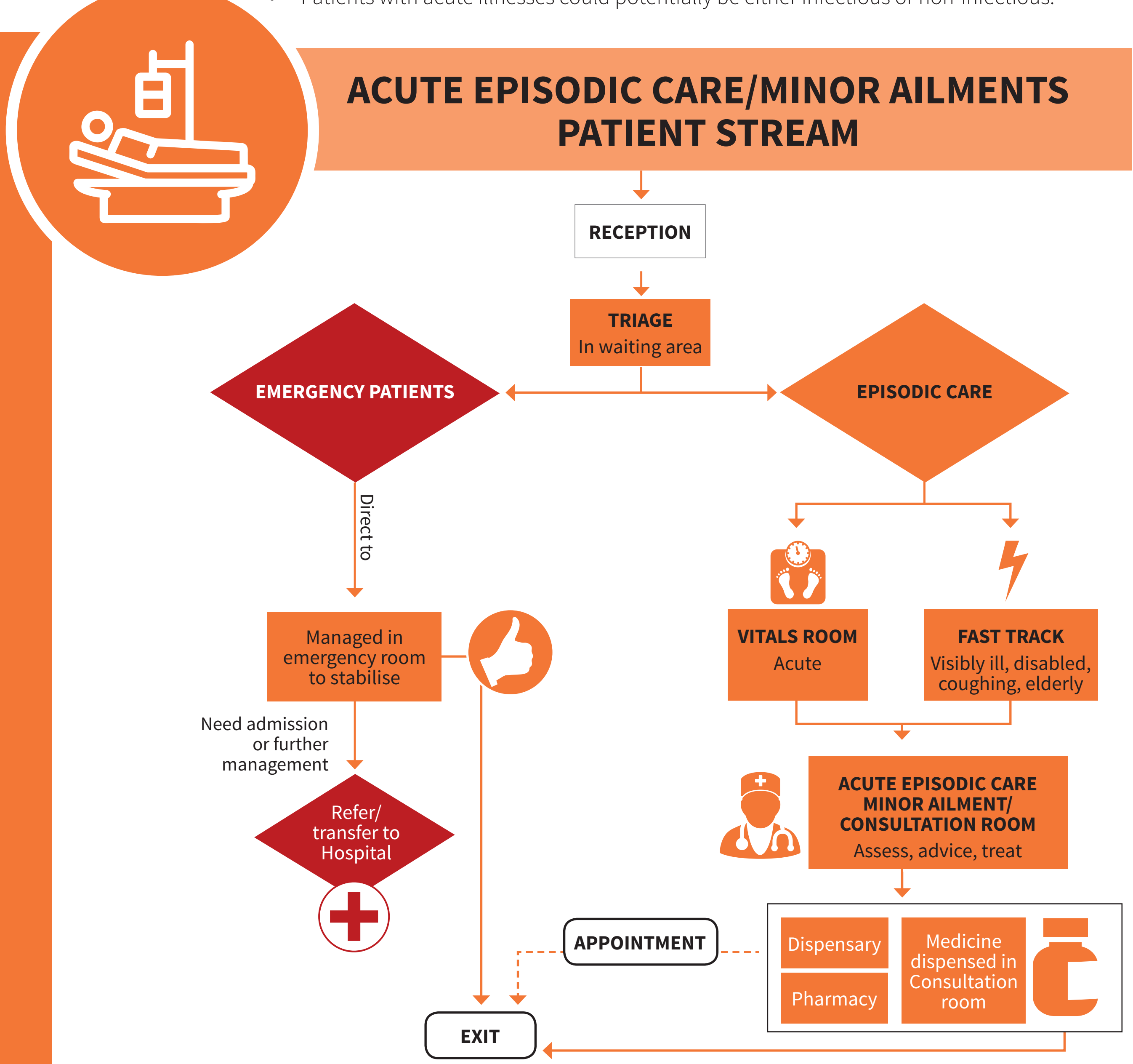


FIGURE 28: ACUTE EPISODIC CARE/MINOR AILMENTS PATIENT STREAM

3.1.1. Patient in need of urgent attention

Any patient requiring *URGENT ATTENTION* should be directed immediately to the Emergency Room. This patient will not queue for the retrieval of clinical records or vital signs but should be provided immediate attention.

RECOGNISE THE PATIENT NEEDING URGENT ATTENTION¡		
• Decreased consciousness • Fitting • Difficulty breathing or breathless while talking • Respiratory rate ≥ 30 breaths/minute • Chest pain • Headache and vomiting • Aggressive, confused or agitated	• Unable to walk unaided • Overdose of drugs/medication • Recent sexual assault • Vomiting or coughing blood • Bleeding • Burn • Eye injury	• Severe pain • Suspected fracture or joint dislocation • Recent, sudden onset weakness, numbness or visual disturbance • Unable to pass urine • Sudden onset facial swelling • Pregnant with abdominal pain/backache/vaginal bleeding • Purple/red rash that does not disappear with gentle pressure
MANAGEMENT Check BP, pulse, respiratory rate, temperature and glucose and ensure patient is seen urgently by nurse or doctor.		

3.1.2. Acute episodic illness (unplanned)

Patients presenting for treatment for acute episodic illnesses will generally be unplanned and are recognised as *non-emergency acute patients*.

- Patients will enter the facility and proceed to the **RECEPTION** to open a clinical record or retrieve the patient's clinical record.
- After completing the **REGISTRATION** process the patient will then be directed to the **TRIAGE or VITAL SIGN STATION** for acute patients (follow the red/orange footsteps).
- Patient will then be directed to the **WAITING AREA** for acute services.
- From the waiting area patients will follow the queue to be consulted in the relevant **ACUTE** consultation room.

Acute episodic illness (potentially infectious) – FAST TRACK

Patients presenting to the facility and having any of the following symptoms:

- Cough (productive or persistent)
- Fever and/or rigors
- Diarrhoea
- Vomiting
- Generalised skin rash

Should be fast tracked and consulted as **PRIORITY** or in the designated **FAST TRACK** consultation room in order to avoid the spread of any potential infections.

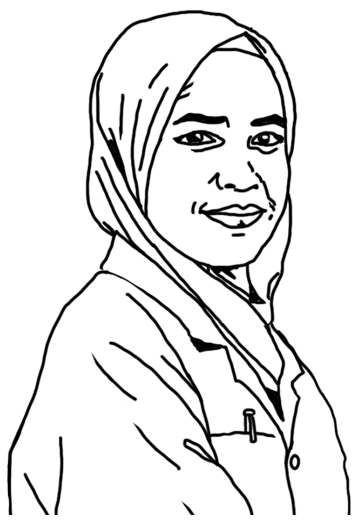
3.1.3. Acute episodic illness (review or follow-up visit)

- Patients that have been treated for acute episodic illnesses and have been advised to return for a review or follow-up visit between *five and seven days* should receive an appointment.
- The patient's clinical records should be stored in the follow-up **ACUTE PATIENTS' CONSULTATION ROOM**.
- Patients should proceed directly to the **DESIGNATED WAITING AREA** and **CONSULTATION ROOM**.
- The patient's vital signs or other non-invasive laboratory investigations should be conducted in the **CONSULTATION ROOM**.
- Patients laboratory or other investigation results should be reviewed in **CONSULTATION ROOM**.
- Patient will be treated and discharged. If the patient requires a repeat or follow-up visit again, then the patient will be booked for review.

3.1.4. Acute episodic illnesses (sick children) – IMCI

Children, (0-6 years) presenting for treatment for acute episodic illnesses will generally be unplanned and are recognised as non emergency acute patients.

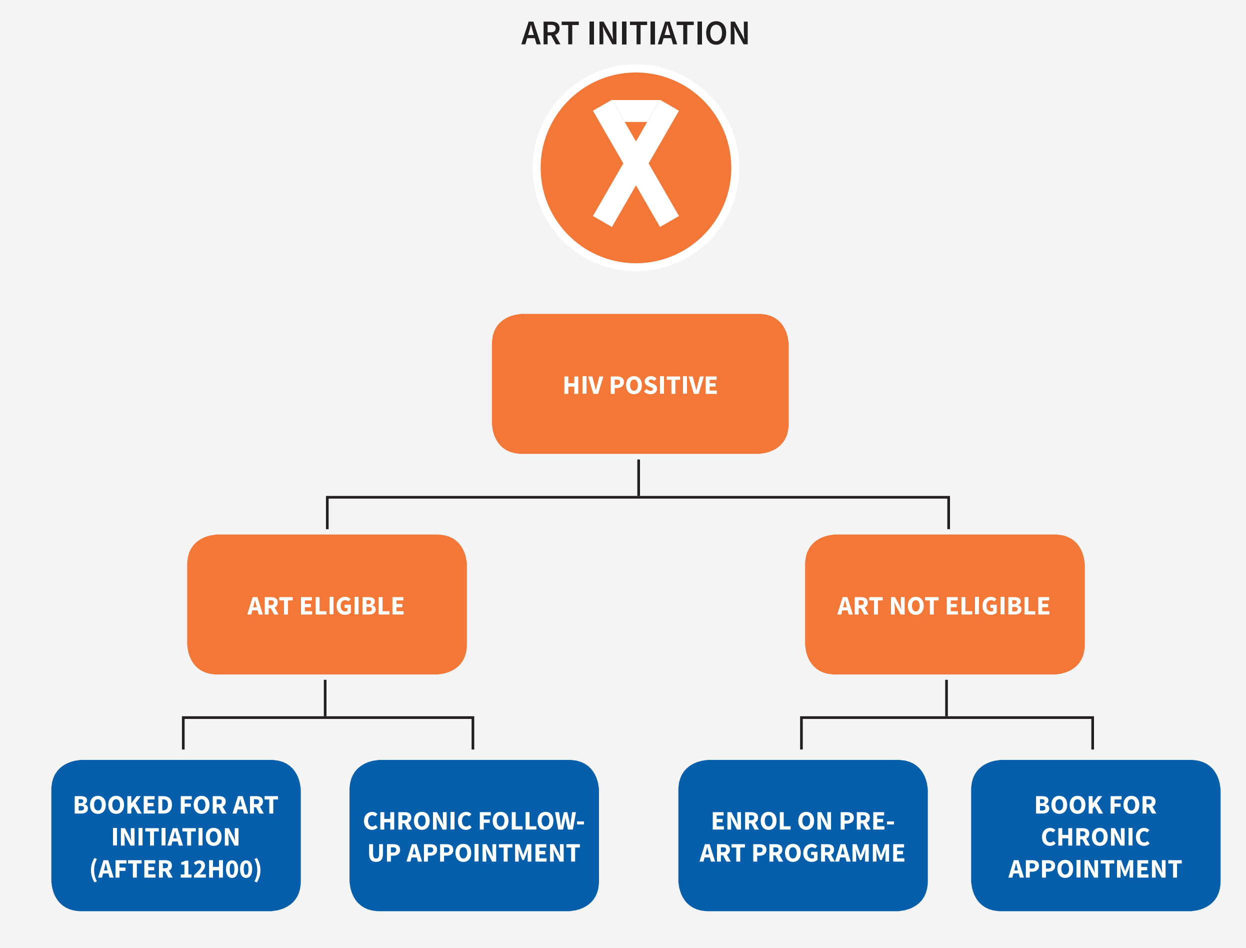
- Patients will enter the facility and proceed to **RECEPTION** to open a clinical record or retrieve the patient's clinical record.
- After completing the **REGISTRATION** process the patient will be directed to the **TRIAGE or VITAL SIGN STATION** for acute patients (follow the red/orange footsteps).
- Patient will then be directed to the **WAITING AREA** for acute services.
- From the waiting area patients will follow the queue to be consulted in the relevant **ACUTE IMCI** consultation room in a large clinic.
- If the child is potentially infectious then the same process as for adults will be followed.
- If the child has a follow-up appointment the process will be similar to that of adults.



All children with acute conditions will be examined in the IMCI room. ***If the patient presents on the same day as mother who has appointment for an ANC or family planning*** the child will be referred to IMCI room. ***If the child has a vaccination visit scheduled but is ill***, they will be seen in IMCI consultation room.

3.1.5. HIV positive patient for ART initiation

A patient that either received provider-based voluntary counselling and testing, or voluntary counselling and testing, and is HIV positive will undergo the necessary evaluation in order to determine eligibility for ART.

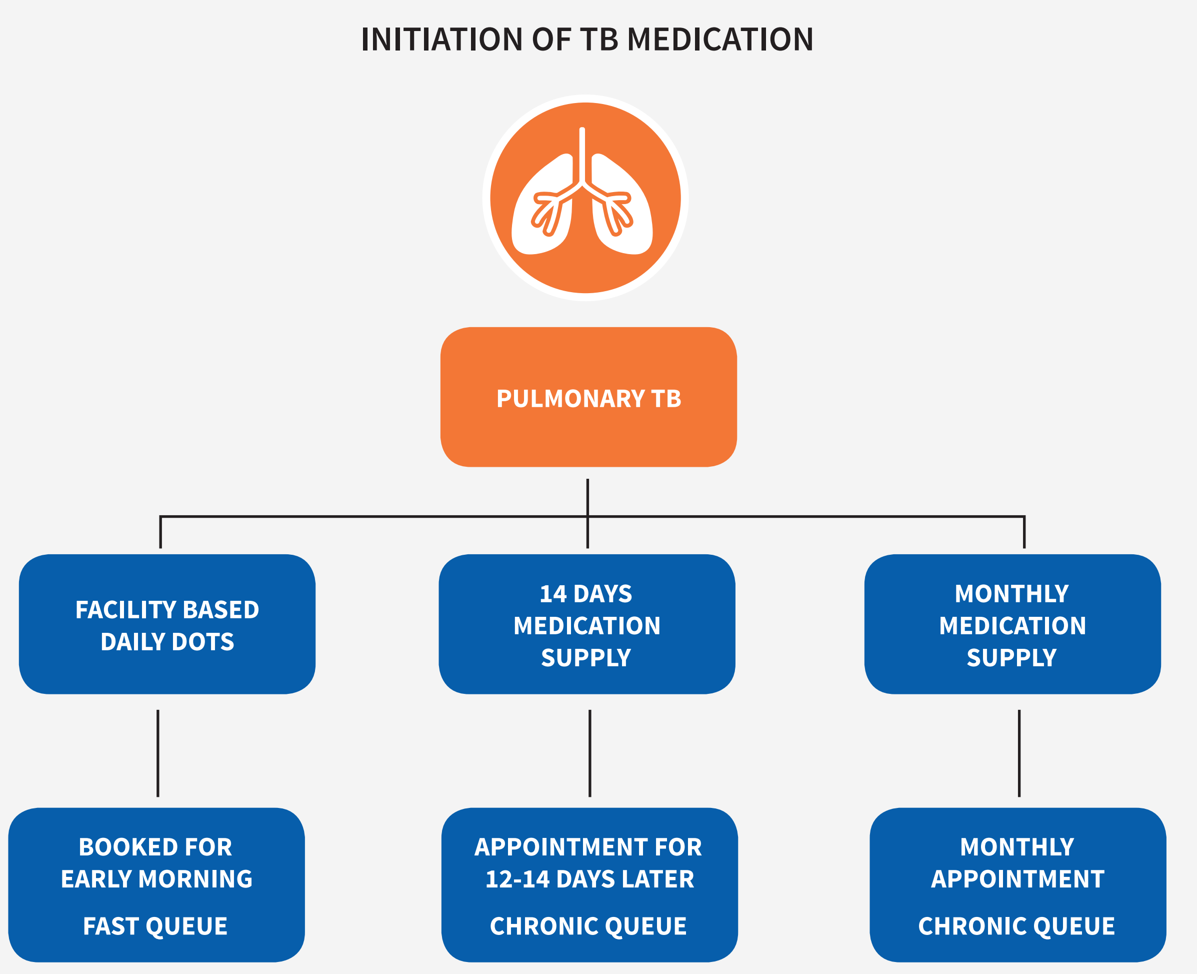


If the patient is not eligible for ART they should be enrolled in the PRE-ART programme and provided with a chronic appointment as per the schedule.

If the patient is eligible for ART they should be booked for the first visit preferably after 12h00 for a full examination, counselling and initiation of treatment in the chronic stream.

3.1.6. Tuberculosis (diagnosis and initiation visit)

A patient who has been newly diagnosed with TB will have a geneXpert test conducted to exclude multi-drug resistance TB.



- Newly diagnosed patients will be prescribed anti-TB medication according to the regimen.
- If the patient is going to be administered facility based DOTS, then they will receive an appointment for the morning. This will be a *Fast Track Queue* only for DOTS patients.
- If the patient is going to receive medication for 14 days then they will receive an appointment for between *12 and 14 days later* but will also be for medication only and go to the *Fast Track Queue* only for DOTS patients.
- If the patient is eligible for a monthly supply of medication, then the patient will be referred to the booking administrator for a monthly return visit and be seen with chronic patients.

A more detailsed diagram of the patient flow for Acute Episodic Care/Minor Ailment stream is shown on the following page.

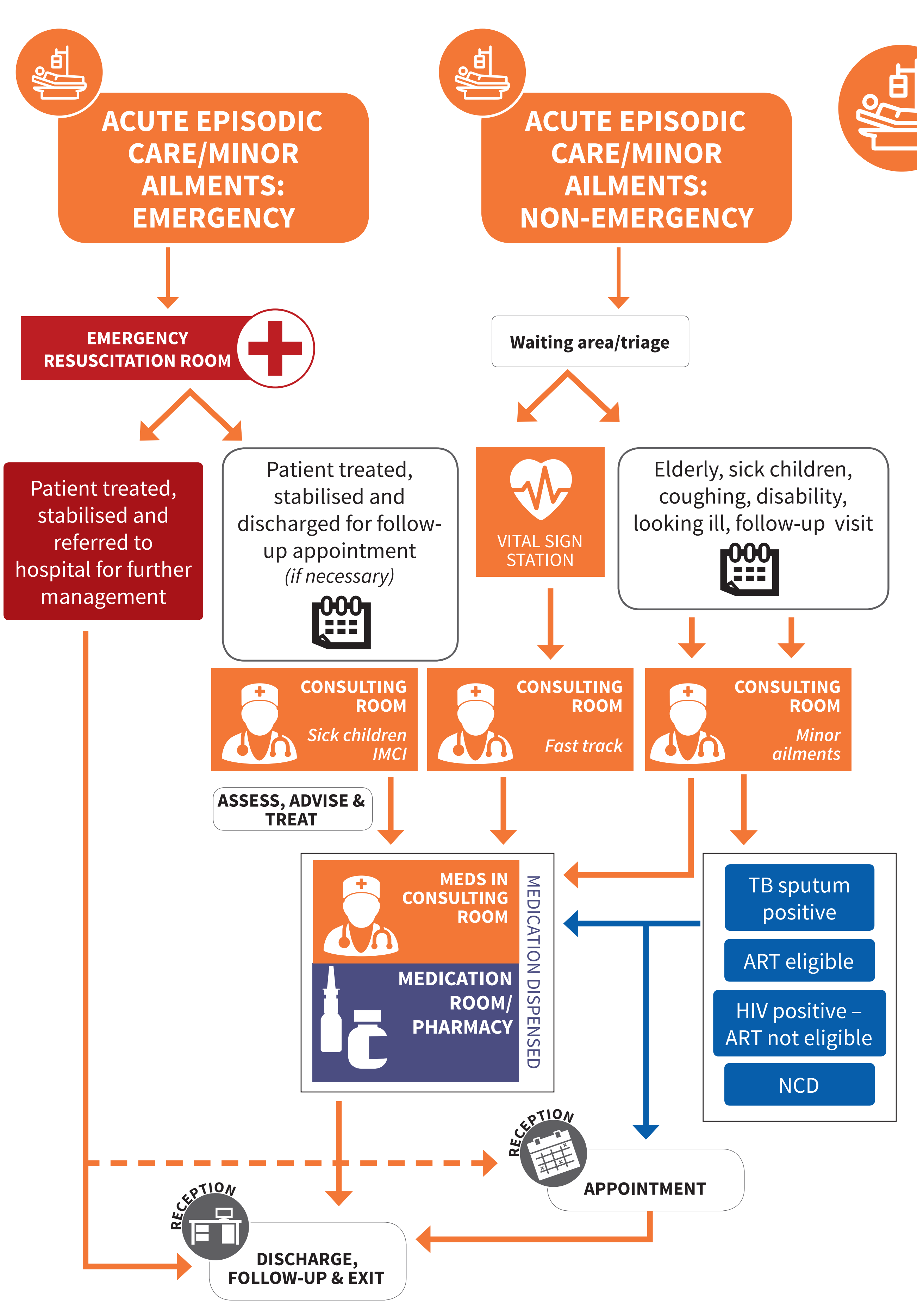


FIGURE 29: NEW PROCESS FLOW FOR ACUTE EPISODIC CARE/MINOR AILMENT PATIENTS

3.2. CHRONIC STREAM OF CARE

Patients requiring long-term repeat consultations for both communicable (HIV, pre-ART and ART; TB) and non-communicable disorders (hypertension, diabetes, chronic obstructive pulmonary disorders, epilepsy, mental health conditions and cardiovascular diseases) are classified as chronic patients.

Chronic patients can be classified as:

- *Unstable* chronic patients
- *Stable* chronic patients
    - Patients for six month review visits or CCMDD assessment
    - Facility based medicine collection (direct or adherence clubs).

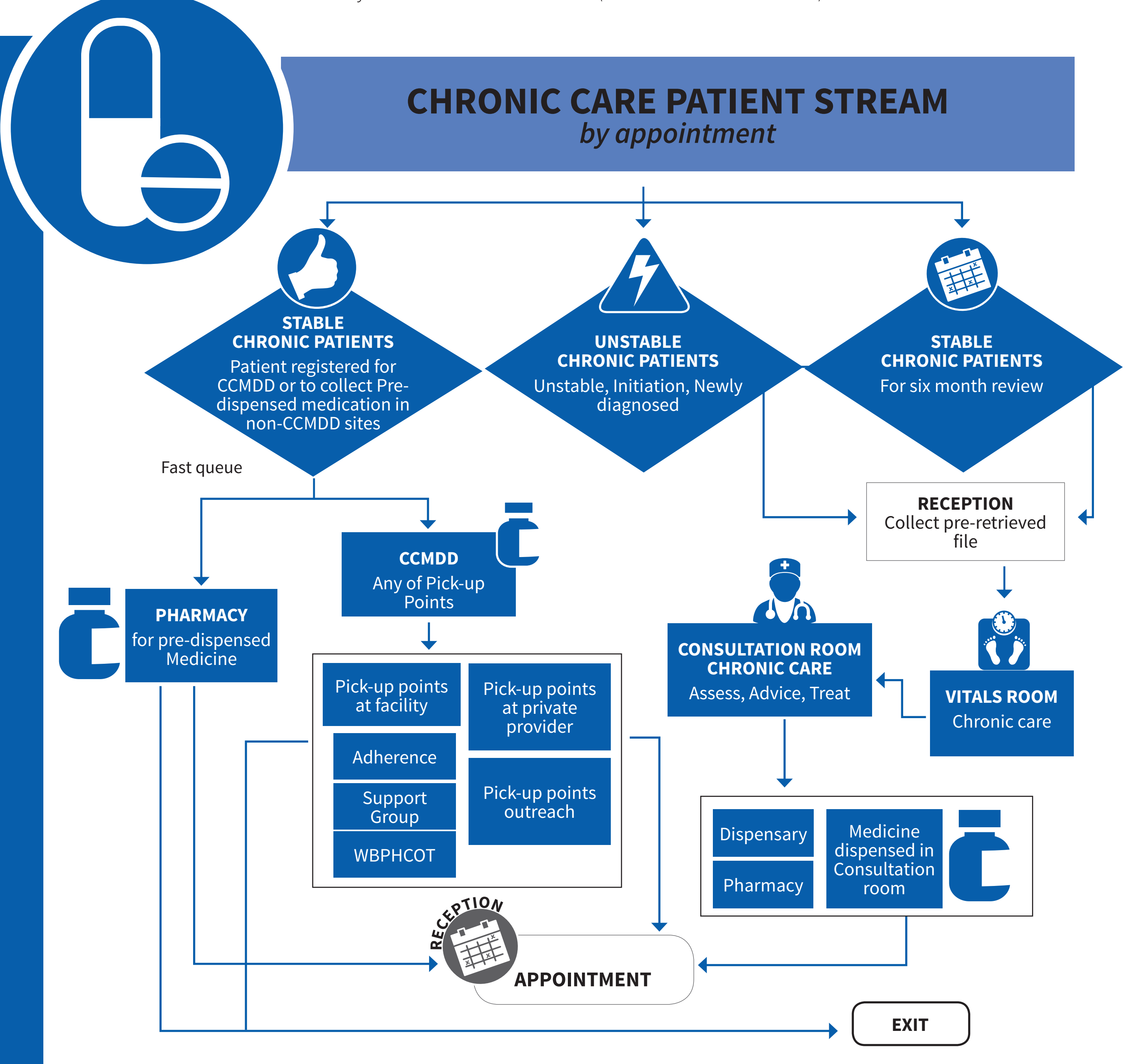


FIGURE 30: CHRONIC CARE PATIENT STREAM

3.2.1. UNSTABLE chronic patient

An unstable chronic patient is a patient whose vital signs parameters are above normal as per APC/PC101, or who displays signs of end-stage organ damage due to the chronic conditions.

- These patients are ***high risk*** patients and require ***pro-active management***.
- Ideally these patients should be referred to the doctor for consultation and should be consulted on a monthly basis.
- These patients should be provided with a scheduled appointment (refer to appointment booking).
- The comments section in the appointment scheduling should reflect '**DOCTOR APPOINTMENT'.**
- The patients' clinical records should be retrieved 48-72 hours prior to the scheduled appointment.
- All the necessary laboratory investigation results should be updated in patient's file.
- When the patient arrives, they will go directly to the chronic vital station.
- After completing the vital signs, the patient should then join the queue to see the doctor.
- After the doctor consults the patient, and if no changes have been made to dosage and medication, the patient should be provided with the pre-dispensed medication.
- If any changes were made to the dosage or medication, additional medication should be dispensed from the consultation room and the prescription chart of the patient should be updated.
- If the patient's parameters are normal and their risk status has declined, the patient can then be categorised as a **STABLE** chronic patient and be referred to the appointment desk to make an appointment or be screened for eligibility for the CCMDD programme.

3.2.2. STABLE chronic patient

A stable chronic patient is a patient whose vital signs parameters are normal (as per APC/PC101) or the patient is adherent and does not display signs of end organ damage due to the chronic conditions.

- When the patient attends for the six month appointment:
  - Their record should be pre-retrieved.
  - The clinical record should be updated.
  - They should proceed directly to chronic vital station
  - They should then be directed to the ***review queue***.
  - A full clinical examination and relevant laboratory investigations should be conducted.
  - If all the patient's parameters are normal, their prescription should be renewed for a further five months.

These patients do not need to be consulted every month and ideally should receive a six monthly physical examination an full consultation

Facility based collection of medication

- The patient should receive an appointment for two months' time depending on medication supply.
- When the patient attends the facility for medication collection, their clinical record should have been pre-retrieved.
- Patient medication should be pre-dispensed.
- Patient should enter the facility and go to the appropriate vital station and then to the fast track room to collect medication (medication dispensing queue).
- At month five, the patient should be provided with an appointment for full review at month six.

CCMDD eligibility

- Currently, if the patient is on ART and has an additional chronic condition, they are eligible for the CCMDD programme. The patient should be assessed for the CCMDD programme and if they fulfill the criteria, the prescription should be forwarded to the CCMDD service provider.
- The patient should then be provided with an appointment for review in six months time(this will include a clinical examination and laboratory investigations if applicable).

Should a patient with ***chronic conditions*** present with an ***acute condition*** on date of appointment whether for review or medication collection, they must be consulted in ***chronic consultation room***.

Should a patient present on any other date then they will join the ***acute/minor ailments queue***.

A detailed flow diagram of the chronic patient process is shown on the facing page.

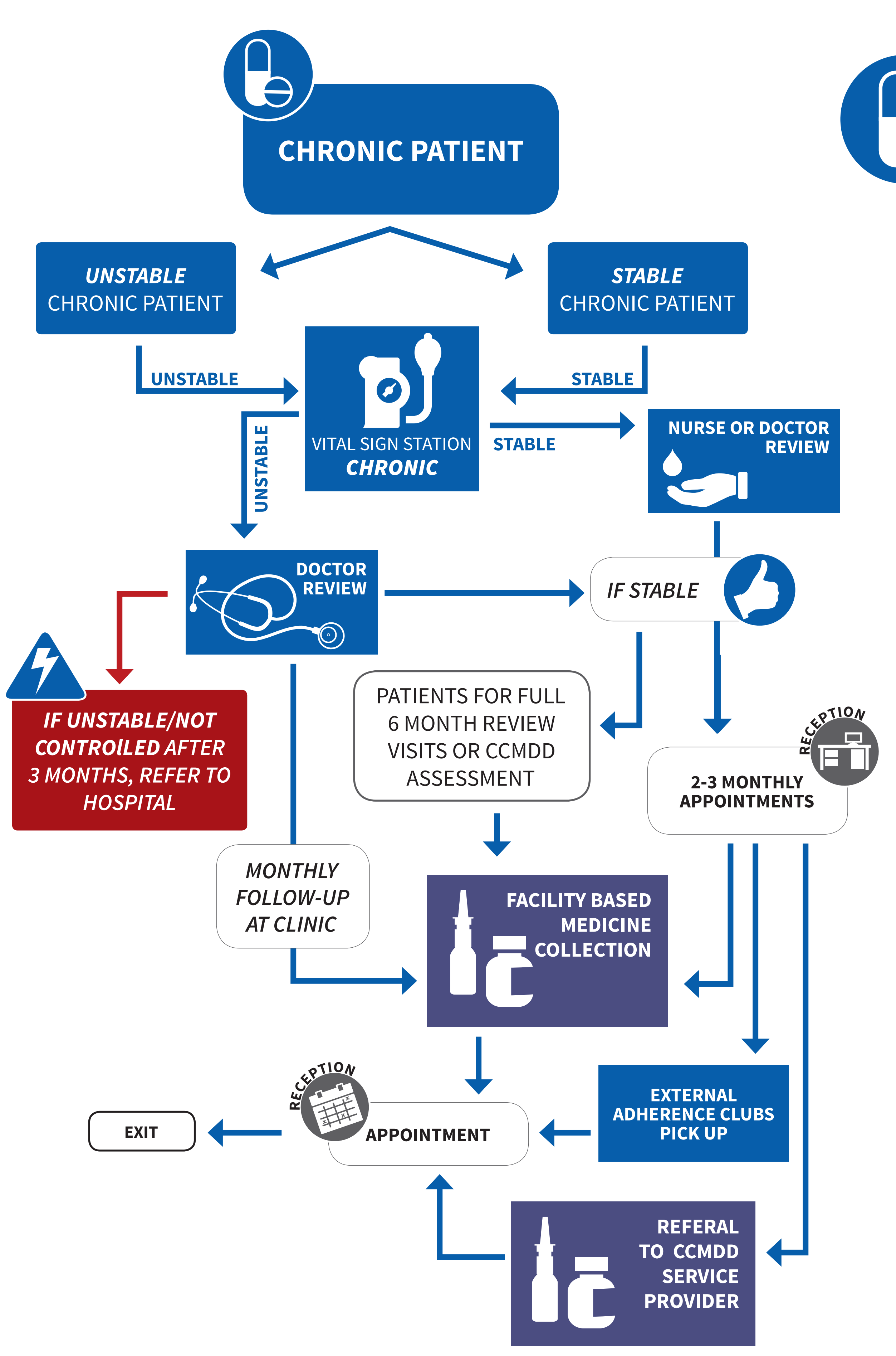


FIGURE 31: NEW PROCESS FLOW FOR CHRONIC PATIENTS

3.3. DOWN REFERRAL OF STABLE PATIENTS

1. A patient is *classified as stable* if:
    a. they have been adherent to appointment schedules for at least *three months*
    b. all vital signs over the *three months* have been normal
    c. no evidence of deterioration in condition or complications exists
2. Where there is no CCMDD attached to the facility, a patient who is *stable* should be down-referred to the CHW for management and should be given an appointment for *review in six months*.
3. A patient who defaults on his or her appointment needs to be traced.

STEPS TO BE FOLLOWED IN DOWN REFERRING A PATIENT TO THE CHW

1. Once the patient is classified as stable, their name should be entered into the down referral diary.
2. The patient should be mapped with a ward based PHC outreach team and specifically a community health worker (CHW).
3. Ideally, the patient should be introduced to the CHW at the facility, so that a communication channel between them can be openned.
4. However, if this is not possible, the patient should be provided with the name and contact details of the CHW.
5. The patient should be asked when the most convenient day and time is for the CHW to visit?
6. The date that the patient should receive the refill of medication should be entered into the diary.
7. The patient should be provided with the clinic number and contact numbers for emergencies.
8. When the patient receives medication, they should complete the *acknowledgement of receipt* and the CHW should return this to the facility for storage in patient’s records.

DOWN REFERRAL DIARY FORMAT/PATIENT DOWN REFERRAL TO CHW

NAME AND SURNAME	PHYSICAL ADDRESS	CONTACT NUMBER	CONVENIENT TIME FOR CHW TO VISIT	LAST DATE BY WHICH MEDICATION SHOULD BE DELIVERED	COMMUNITY HEALTH WORKER ALLOCATED

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 medication delivery					
Dispenser's signature (to be completed after checking, placing, labelling and sealing packet)					
Community health worker's signature upon receipt of medication (sealed bag)					
Patient's signature on opening of sealed bag and checking medication					
Medication not delivered					

3.4. PREVENTIVE/PROMOTIVE STREAM OF CARE (MC&SRH)

This stream of care primarily involves prevention and promotion services for mothers and children.

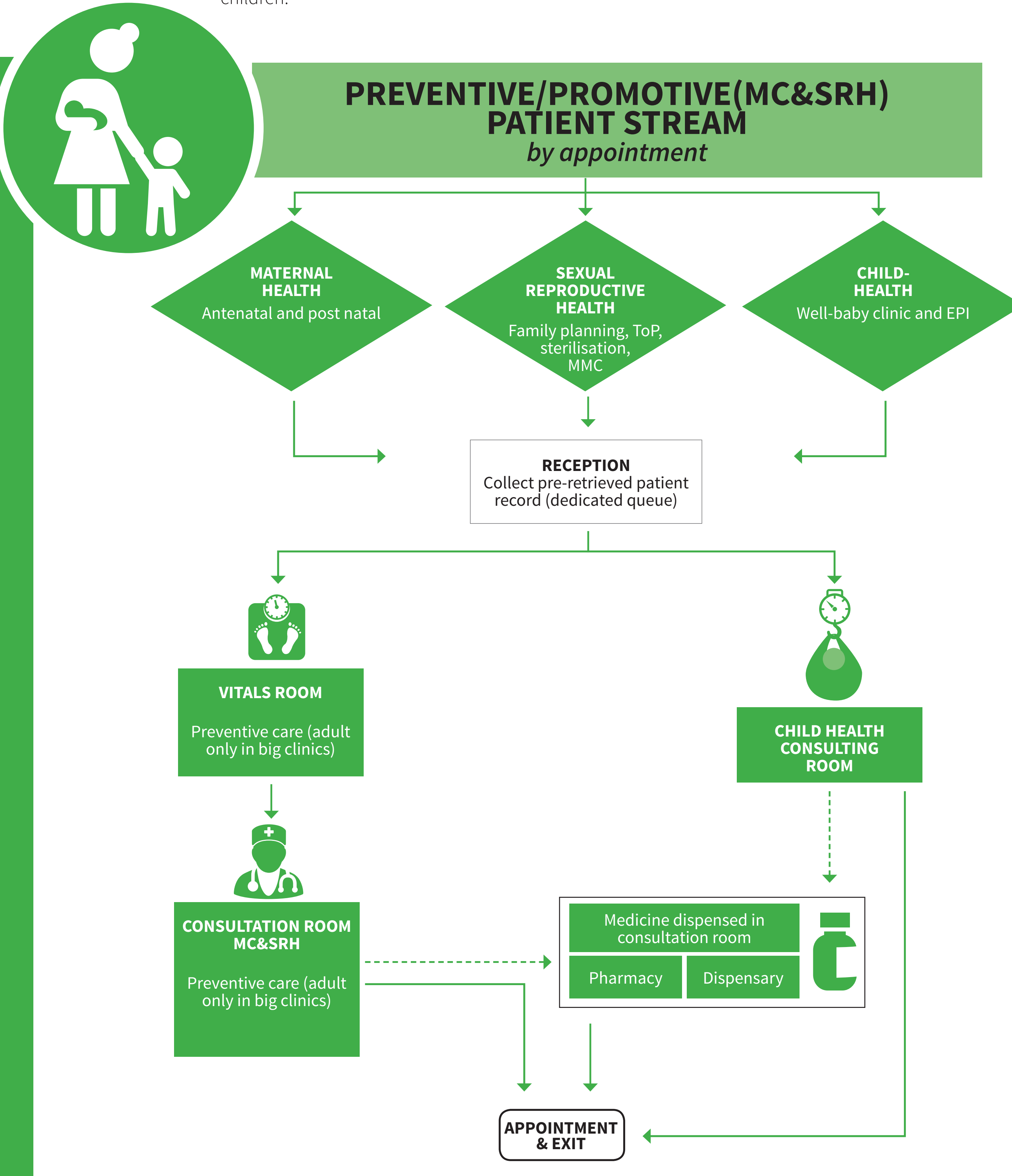


FIGURE 32: PREVENTIVE/PROMOTIVE CARE (MC&SRH) PATIENT STREAM

3.3.1. Antenatal care

When a female patient presents to the facility with unknown reproductive health status or for confirmation of pregnancy, the patient will be consulted in the acute/minor ailments or episodic stream of care.

Once the diagnosis is made, the patient undergoes health screening as per BANC plus visit checklist.

- If the patient is found to be a high risk, they will be referred to the MC&SRH stream for a full consultation and/or referral to higher level of care immediately.
- If the patient is confirmed to be at an early stage (<14 weeks) of pregnancy and is at minimal risk, they should receive a booking for a 1st appointment.
- Ideally, the first visit should occur before 14 weeks of gestation. However, regardless of the gestational age, any pregnant woman attending antenatal care for the first time must undergo the procedures of the 'first visit'. This will take between 30 and 40 minutes.

Follow-up visits have been found to be most effective at 20, 26, 30, 34, 36, 38 and 40 weeks' gestation.

- These dates coincide with performing examinations and tests at times that are of most benefit to the pregnant woman and which give the greatest chance of detecting problems that can be treated.

** Findings from a large international study run by the WHO have recently been updated and suggest that concentrating visits in the period from 26 to 38 weeks may reduce stillbirths related to IUGR and hypertension.

Adolescents and youth (10-24 years) should be consulted ***after school hours***. Once an adolescent is diagnosed as pregnant then an ***adult female record*** should be opened.

ANC HISTORY

Obstetric history
- Previous still birth
- Previous neonatal death
- Previous low birth weight baby (<2.5 kg)
- Previous large baby (>4.5 kg)
- Previous pregnancy admission for hypertension or pre-eclampsia/eclampsia
- Previous caesarean section
- Previous myomectomy
- Previous cone biopsy
- Previous cervical cerclage

Current history
- Diagnosed or suspected multiple prefnancy
- Age <16 years Age 37 years
- Rhesus isoimmunisaion in previous or current pregnancy
- Vaginal bleeding
- Pelvic mass
- Systolic blood pressure ≥140mmHG and/or diastolic blood pressure ≥90mmHg

General medical conditions
- Diabetes mellitus
- Cardiac disease
- Kidney disease
- Epilepsy
- Asthma on medication
- Active turberculosis
- Known substance abuse including alcohol
- Any severe medical condition

Risk factors requiring hospital delivery
- Previous postpartum haemorrhage
- Parity ≥5

Further risk factors that arise during antenatal care
- Aneamia not responding to iron tablets
- Uterus large for dates (≥90th centile symphysis-fundal height)
- Uterus small for dates (≤10th centile symphysis-fundal height)
- Symphysis-fundal height decreasing below 10th centile)
- Breech o transverse lie at term
- Extensive vulval warts that may obstruct vaginal delivery
- Pregnancy byond 41 weeks
- Abnormal glucose screening (GTT or random blood sugar)
- Reduced fetal movements after 28 weeks

PREGNANCY NEWLY DIAGNOSED AT FACILITY	PREGNANCY CONFIRMATION	SUBSEQUENT VISITS
• A 20 working day cycle will be used to determine the number of patients to be consulted in order to cater for pension days, public holidays as well as weekends. • The booking is made for a Monday to Friday work week. • Determine the number of patients to be consulted per diagnostic condition by taking the average and dividing it by 20. • This will then provide the workload per day and projected number of patients to be scheduled.	• Some patients at an early stage of pregnancy may come in for pregnancy confirmation. • Women who present to primary care clinics and are found to be low risk should be referred to the appointment desk for the first antenatal booking. • Patients who are at high risk must be referred to ANC clinic for immediate first visit consultation. • Those who request termination of pregnancy should be appropriately counselled and referred.	• After the first antenatal visit, the patients should receive appointment schedules for the remainder of the pregnancy. They should also be provided with details of a contact in the event of an emergency. • A ‘basic antenatal care’ schedule of four follow-up visits is provided for women without any risk factors. • Following the early booking visit (preferably <12 weeks), return visits should be scheduled for at 20, 26, 30, 34, 36, 38 and 40 weeks’ gestation, and 41 weeks if still pregnant by then This is not applicable for women with risk factors, whose return visits schedules will depend on their specific problems.

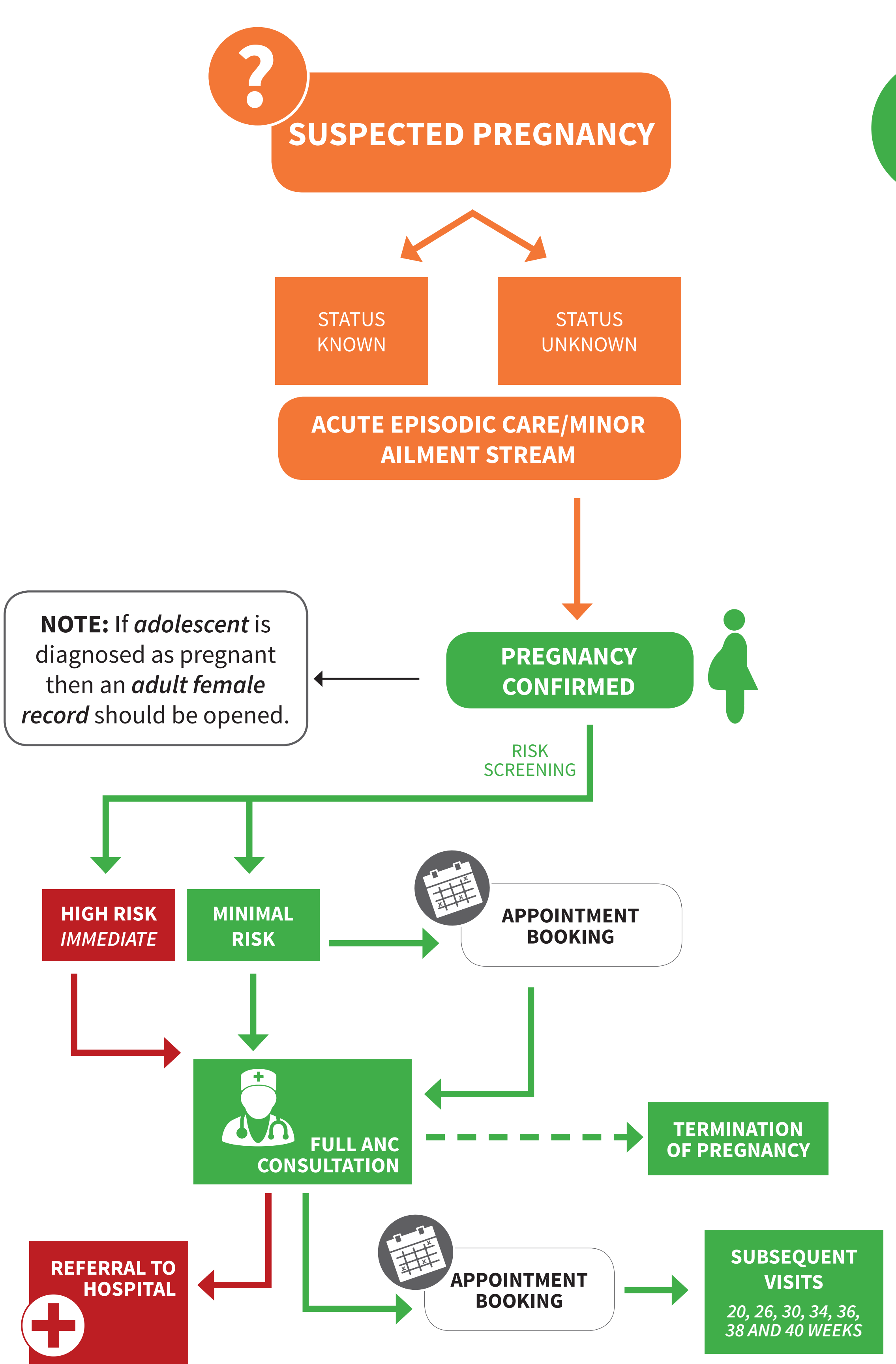


FIGURE 33: PROCESS FLOW FOR ANC PATIENTS

MATERNAL, CHILD & SEXUAL REPRODUCTIVE HEALTH

BY APPOINTMENT

ANTENATAL CARE	POST NATAL CARE	FAMILY PLANNING, STERILISATION, TERMINATION OF PREGNANCY & MMC	WELL-BABY AND IMMUNISATION

RECEPTION

COLLECTION OF RECORDS

VITAL SIGN STATION *FOR ADULTS*

ASSESS, ADVISE & TREAT

CONSULTATION ROOM *FOR ANTENATAL, POST NATAL AND FAMILY PLANNING*

CONSULTATION ROOM *FOR CHILDHEALTH: WELL-BABY & IMMUNISATION*

ASSESS & ADVISE

MEDICATION DISPENSING (PHARMACY, MEDICINES ROOM, CONSULTATION ROOM)

APPOINTMENT BOOKING

EXIT

FIGURE 34: NEW PROCESS FLOW FOR SCHEDULED MC&SRH

ORGANISATION OF ANC

Pregnant woman

Rapid assessment and management

First visit

Complete Clinic checklist

No special health condition or risk factor

Special health condition or risk factor

Follow-up at 20 weeks

Complete Clinic checklist

Refer to hospital

Problem

No risk

Follow-up at 26, 30, 34, 36, 38 weeks

Complete Clinic checklist

Problem

Combined care

Gestational age incorrect and re-assign

Hospital care

No risk

Gestational age uncertain or problem

Follow-up at 40 weeks

Present to hospital at 41 weeks for induction of labour

Doctor or senior midwife confirms gestational age

SOURCE: BASIC ANTENATAL CARE PLUS –STANDARD OPERATING PROCEDURES, NATIONAL DEPARTMENT OF HEALTH

ANTENATAL BOOKING PLAN

	VISITS							
First visit for all women at first contact with clinics, regardless of gestational age. If first visit later than recommended, carry out activities up to that time	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
DATE :								
Approximate gestational age (weeks).	**<14**	**20**	**26**	**30**	**34**	**36**	**38**	**40**
Classifying form indicating eligibility for BANC								
History taken								
Full clinical examination								
Estimated date of delivery calculated								
Blood pressure taken								
Maternal height/weight/MUAC								
Haemoglobin test								
RPR performed								
Urine tested for protein, sugar, nitrites								
Rapid Rh performed								
HIV counselling and testing		Retest every 12 weeks if negative						
ART for HIV-infected women	Viral load monitoring as per guidelines							
Tetanus toxoid given								
Iron and folate supplementation provided								
Calcium supplementation provided								
ART given for HIV positive women								
Information for emergencies given								
Antenatal record completed and given to woman								
Asked if fetal movements felt and normal								
TB symptom screen								
Clinical examination for anaemia								
Urine tested for protein, glucose								
Uterus measured for growth - twins, IUGR								
Instructions for delivery/transport to institution								
Recommendations for lactation and contraception								
Detection of breech presentation and referral								
Remind woman to bring antenatal record in labour								
Doctor or senior midwife to review gestational age								
Give hospital visit date at 41 weeks for induction								
Initials staff member responsible								

Additional Visits

Date	Reason	Action/Treatment

SOURCE: BASIC ANTENATAL CARE PLUS – STANDARD OPERATING PROCEDURES, NATIONAL DEPARTMENT OF HEALTH

THE POSTNATAL CARD

Patient Details Discharge (Mother)

Date: ____________________

Exam by: ____________________

Delivered at: ____________________

Mother's Name:			
Hosp No			
Address: Tel/cellphone no			
Age:	Parity:	Gravidity	
ANC complications			
Delivery route :			
Birth weight			
Date of delivery			
Gestational age			
Complications in labor:			
Postpartum course:			
UMAC	Rh	RPR	Hb
Code:			
Vitamin A given	YES	NO	
Iron/folate given	YES	NO	
Type of contraception			

*** If ticks in shaded area comment as to why on back**

Examination within 1 week (Mother)

Date: ____________________

Exam by: ____________________

Clinic: ____________________

Clinic No____________________

+Ask the mother the following

Feeling unhappy?	YES	NO
Poor appetite?	YES	NO
Problems with infant feeding?:	YES	NO
Cough/ Breathing difficulties?	YES	NO
Lochia foul smelling?	YES	NO
Heavy vaginal bleeding?	YES	NO
Urinary incontinence?	YES	NO

+Examine the following

UMAC:	Temp	Pulse	BP
Pale:	YES	NO	
If breast feeding, nipples cracked /breast inflamed	YES	NO	
Uterus involuted appropriately:	YES	NO	
Uterine tenderness	YES	NO	
If C/S, is wound infected:	YES	NO	
Sutures removed	YES	NO	
Episiotomy infected:	YES	NO	

+Test the following

Urine normal	YES	NO

***If ticks in shaded areas comment on back → Refer, if cannot treat**

Examination at 6 weeks (Mother)

Date: ____________________

Exam by: ____________________

Clinic: ____________________

+Ask the mother the following

Able to resume normal activities	YES	NO
Problems with infant feeding?:	YES	NO
Cough/ Breathing difficulties?:	YES	NO
Problems with C/S wound?	YES	NO
Problems with episiotomy?:	YES	NO
Vaginal discharge?	YES	NO
Urinary incontinence?	YES	NO

+Examine the following

UMAC	Temp	Pulse	BP
If breast feeding, are nipples cracked / breast inflamed	YES	NO	

+Test the following

Urine normal:	YES	NO	
Hb g/l (value)			
Hb< 10g/d l	YES	NO	

***If ticks in shaded areas comment on back → Refer, if cannot treat**

CD4 Taken	YES	NO	N/A
Type of contraception			

*** If ticks in shaded area comment as to why on back**

Patient Details Discharge (Infant)

Date: ____________________
Exam by: ___________________
Delivered at: ______________

Infant's name:			
Feeding?	EBF	FF	Other
Feeding well		YES	NO

Examination at discharge			
Birth weig ht		Gestational age	
Jaundice:		Respiratory problems	
YES	**NO**	**YES**	**NO**
CVS problems		Abdomen problems	
YES	**NO**	**YES**	**NO**
Genitalia problems		CNS problems	
YES	**NO**	**YES**	**NO**
Umbilical problems		Hip dislocation:	
YES	**NO**	**YES**	**NO**

If ticks in shaded area comment on back as to problem and actions taken

NVP	**YES**	**NO**	**N/A**
AZT	**7days**	**28days**	**N/A**

Permission for PCR		
YES	**NO**	**N/A**

Mother's name
Signature(mother)
Signature(Witness)

Examination within 1 week (Infant)

Date: ____________________
Exam by: ___________________
Clinic: ______________________

Infant's name

+Ask the following

Feeding?	EBF	FF	Mixed
Problems		**YES**	**NO**
Passed urine?		**YES**	**NO**
Passed stool?		**YES**	**NO**

+Examine the following

Temperature (axilliary)		
Pale	**YES**	**NO**
Jaundiced:	**YES**	**NO**
Conjunctivitis	**YES**	**NO**
Umbilical cord smelly:	**YES**	**NO**

*** If ticks in shaded area comment on back. Refer, if cannot treat**

Examination at 6 weeks (Infant)

Date: ____________________
Exam by: ___________________
Clinic: ______________________

+Ask the following

Feeding?	EBF	FF	Mixed

Problems	**YES**	**NO**
Excessive sleeping/ Not alert?	**YES**	**NO**

+Examine the following
Record weight and head circumference on Road to Health Chart

Jaundice:	**YES**	**NO**
Pale	**YES**	**NO**
Cyanosis:	**YES**	**NO**
Responds to sound:	**YES**	**NO**
Eyes (white spot)	**YES**	**NO**
Thrush	**YES**	**NO**
Fontanel abnormal (anterior)	**YES**	**NO**
Heart murmur	**YES**	**NO**
Abdominal mass:	**YES**	**NO**

*** If ticks in shaded areas comment on back. Refer, if cannot treat**

- **Vaccinate**

PCR test:	**YES**	**NO**	**N/A**
Consent given:	**YES**	**NO**	**N/A**
Bactrim prophylaxis:	**YES**	**NO**	**N/A**
Vitamin A supplementation:	**YES**	**NO**	**N/A**

*** If ticks in shaded area please explain why on back**

SOURCE: ESSENTIAL POST NATAL CARE (EPOC)

3.3.2. Family planning

FIRST VISIT	SUBSEQUENT VISITS
Patient will enter the facility through the acute episodic/minor ailment stream, be registered, have vital signs conducted and any medical contra-indications will be excluded. The patient will then receive their contraception in the Acute Section and be transferred to the appointment desk for subsequent visits in the MC&SRH stream.	Patient will receive appointments for next visits. Patient will present directly to the maternal and women's health section and then be fast-tracked to the relevant consultation room or they will be provided with pre-dispensed oral contraception.

Adolescents and youth should be consulted ***after school hours***.

3.3.3. Cervical smears

- All eligible women attending the facility, irrespective of the stream of care, must receive cervical smears on the same date of their consultation if possible.
- There will be no appointments or special days for cervical smears. Cervical smears should be done by all healthcare practitioners during the same consultation.
- Cervical smear results should be checked regularly and patients contacted if any abnormalities are reported.

3.3.4. Well-baby and immunisation

- A designated area for post natal care, well-baby checks and immunisation should be available.
- Routine post natal care and well-baby check-up visits may not be planned if patients have not delivered at the current facility and therefore should be anticipated.
- First immunisation visits may also not be a planned visit.

For these reasons, *the facility should use historical data* to estimate the number of patients that will be attending the facility and provide open slots in the appointment schedule to accommodate them.

Follow-up immunisation and baby checks:

- Follow-up appointments and subsequent immunisations should be scheduled. The mother should receive coinciding appointments for post natal care, sexual reproductive health chronic care.
- For post natal care and/or sexual reproductive health services the patient should not have to go to another room to be seen by another healthcare practitioner.
- However, if the mother is on chronic medication, services may have to be delivered in another stream, if this is the case the patient should be fast-tracked.

Adolescents and youth (10-24 years) should be consulted ***after school hours***. Once an adolescent is diagnosed as pregnant then an ***adult female record*** should be opened.

3.5. HEALTH SUPPORT SERVICES

The Health Support Services stream of care includes the following services:

- Oral health
- Speech and audiology
- Physical rehabilitation (physiotherapy, occupational therapy)
- Optometry
- Mental health (psychology, mental health nurse)

These services are not available daily at most facilities and therefore will need to be scheduled in most cases. However, in facilities where the services are available the service provider will receive *internal referrals*, *down referrals* and *scheduled appointments*.

1

Internal referral

Patients will already have a facility clinical record and should be referred directly for assessment as an unplanned visit if urgent, or given an appointment.

2

Down referrals

Patient may sometime be referred from hospitals or other health facilities for assessments. Ideally, the referring centre should call and receive an appointment date. However, this is not always possible. When these patients arrive with the appropriate referral letters, a facility specific clinic record should be opened for the patient. The patient should then be directly referred to the relevant service as an unplanned appointment.

3

Follow-up patients

Patients will be scheduled to see health support professionals. The patient's file will be pre-retrieved and the patient will go directly to the designated waiting area unless patient has come for other services.

PRE-IMPLEMENTATION
- BRIEFING OF STAFF
- SELECTION OF START DATE
- FACILITY ICSM TEAM
- COMMUNITY AWARENESS

DATA COLLECTION
- FACILITY WALK THROUGH
- FACILITY DATA COLLECTION
- WAITING TIME SURVEY
- HUMAN RESOURCE TRAINING AUDIT

DATA ANALYSIS
- NUMBER OF PATIENTS TO BE BOOKED DAILY
- NUMBER OF CONSULTATION ROOMS PER STREAM
- PROCESS FLOW
- HUMAN RESOURCE TRAINING REQUIREMENTS
- MANAGEMENT OF PATIENT RECORDS

PRE-IMPLEMENTATION PREPAREDNESS

ADMINISTRATIVE RE-ORGANISATION
- CREATING A SAFE ENVIRONMENT
- SIGNAGE (INTERNAL AND EXTERNAL)
- SINGLE ADMINISTRATIVE POINT
- MANAGEMENT OF APPOINTMENTS

SERVICE RE-ORGANISATION
- FOUR STREAMS OF CARE
- APPOINTMENTS
- FAST QUEUE
- CCMDD OR PRE-DISPENSING
- DOWN REFERRAL

HEALTH SERVICE RE-ORGANISATION

CLINICAL MANAGEMENT SUPPORT
- CLINICAL GUIDELINES AND TOOLS
- CLINCIAL STATIONERY & PATIENTS RECORDS
- TRAINING OF STAFF
- DR & DISTRICT CLINICAL SPECIALIST TEAM

'ASSISTED' SELF- MANAGEMENT
- COLLABORATION WITH WARD BASED OUTREACH TEAM
- HOUSEHOLD VISITS
- ADHERENCE CLUBS AND SUPPORT GROUPS

POPULATION HEALTH AWARENESS & SCREENING
- HEALTH AWARENESS DAYS
- UNIVERSAL TEST AND TREAT
- INTEGRATED SCHOOL HEALTH TEAM
- WARD BASED OUTREACH TEAMS

STRENGTHENING INDIVIDUAL AND POPULATION HEALTH

MONITORING AND EVALUATION
- WAITING TIME SURVEY
- PATIENT EXPERIENCES SURVEY
- CLINICAL AUDIT
- PERFORMANCE INDICATORS
- ADHERENCE TO APPOINTMENTS SURVEY
- DASHBOARD

SECTION FIVE
CLINICAL MANAGEMENT SUPPORT

CLINICAL MANAGEMENT SUPPORT | CLINICAL GUIDELINES AND TOOLS | CLINCIAL STATIONERY & PATIENTS RECORDS | TRAINING OF STAFF | DR & DISTRICT CLINICAL SPECIALIST TEAM

This section provides an overview of the clinical tools that are available to support the optimal management of patients at Primary Healthcare level.

The aim of the clinical support component of the ICSM is to improve the quality of care provided to patients, thereby improving the clinical outcomes and reducing complications.

INTRODUCTION

When a patient presents to the health facility with symptoms or signs, this represents the clinical phase of a disease. Prior to this, the person is usually asymptomatic and in the pre-clinical phase of the disease. The post diagnosis stage may classify as cured, be able to continue to live with the disease (chronic) or may have deteriorated and died. These different phases represent the natural history of the disease (Figure 34).

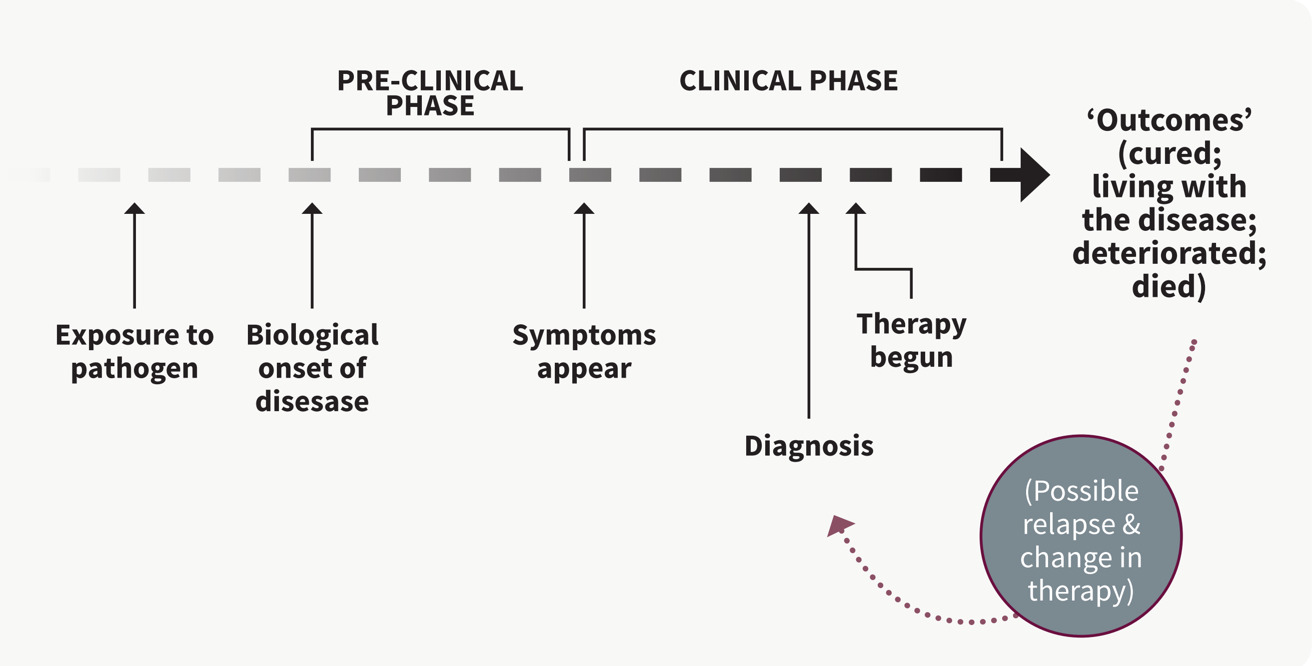


FIGURE 35: NATURAL HISTORY OF THE DISEASE PROCESS

An individual passes through the various stages of life (pre-conception, conception, antenatal, new born, infant, child, adolescent, young adult, middle aged, old age and finally death). Each of these phases require interventions that are specific for the respective period of life.

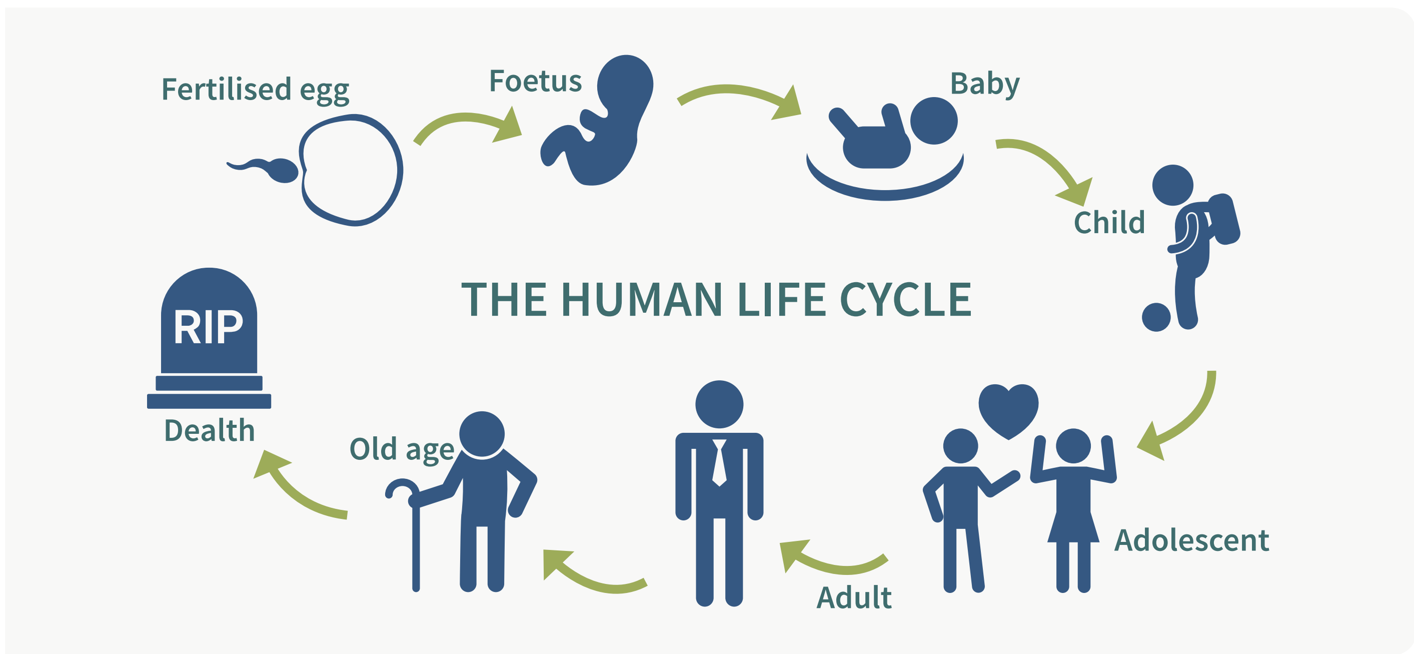


FIGURE 36: HUMAN LIFE CYCLE

Health services are required to take cognisance of both the human life cycle, as well as the natural disease process. A continuum of care comprising primary prevention, screening, and tertiary prevention is required during the different phases of life.

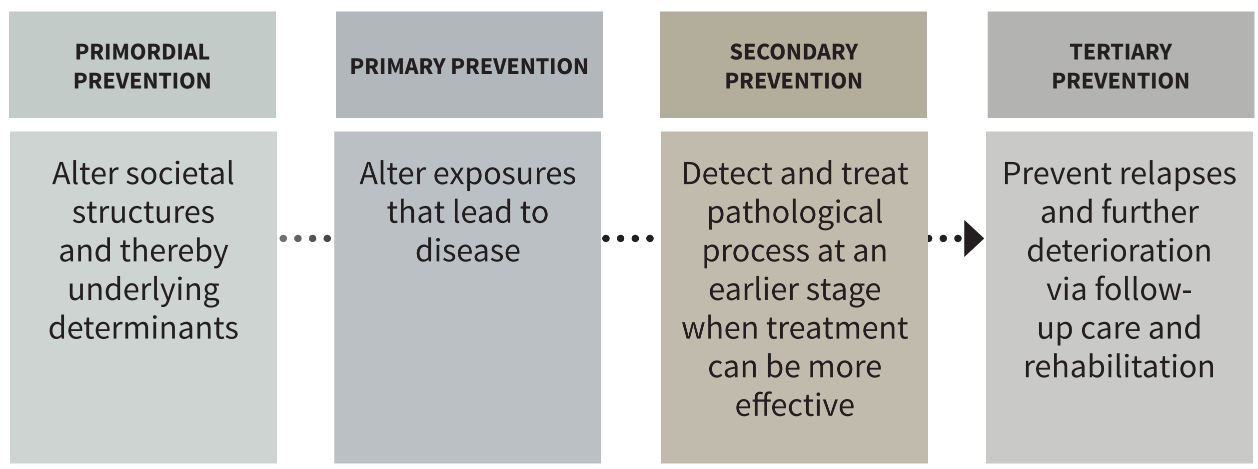


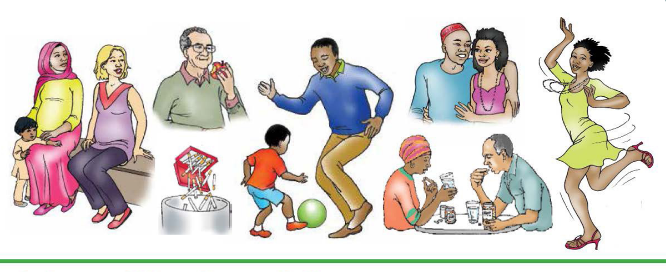
FIGURE 37: CONTINUUM OF CARE

The National Department of Health has embarked on a process of developing evidence-based guidelines that will support service providers to offer holistic care at the various stages of life and across the continuum. Each service provider should have a copy of these guidelines that are accessible during the patient's consultations either in hard copies or electronically. The guidelines and manuals are described in the following pages and are available at *www.idealclinic.org.za*.

1. CLINICAL GUIDELINES

1.1 HEALTH PROMOTION FOR ALL

WHAT?	Health Promotion Tool featuring illustrated patient and service provider information in the form of action messages.
WHY?	Empower the patients with the necessary information to reduce complications.
WHEN?	To be used in the consultation room.
HOW?	Action messages that provide the patient with direction on lifestyle changes required, encouraging patients towards self-management.
WHO?	Doctors and nurses during consultation.



Health for All

Health Promotion tool for use by health care professionals

introduction

WHAT IS IT?

This is a clinical tool for health promotion in Primary Health Care. It is designed specifically for use during consultation between the health care professional (eg nurse or doctor) and the person* who comes for health care.

WHY?

The increase in chronic conditions (communicable and non-communicable diseases, and mental health) needs to be actively addressed in order to promote good health and prevent disease in the population. This tool helps to identify risk factors that threaten good health or worsen existing conditions. It will assist doctors and nurses in primary health care to recognise risks and make patients aware of these risks. By offering ways to reduce risks, it will aid patients to reduce the effect of risk behaviour before disease develops and those patients who have existing conditions to prevent further complications.

WHO BENEFITS?

The information in this tool is aimed at the patient. It is framed in a way that this information can be given to patients in a simple manner and that is easily understood. The messages should be used by the doctor/nurse to encourage patients towards self-management of their health or existing conditions.

HOW DOES IT WORK?

This tool contains the basic facts (TO KNOW) on 22 main conditions and 7 key risks. It provides information that the health care professional (HCP) can share with the patient, and identify key risks that threaten the patient's health .

The action messages (TO DO) give direction to the patient to make informed choices that will improve health.

These messages have been designed to target the general population. At the individual level, the tool can be used to tailor the messages to fit the profile of each patient according to his or her particular health needs.

The content and messages are aligned with the Adult primary Care (APC) clinical guidelines and National Department of Health policies.

WHAT ARE WE AIMING FOR?

To shift from an approach of making a clinical diagnosis to forming a patient profile that includes the health risk factors.

This then facilitates a shift from purely clinical care to patient management that includes behaviour change and self-care.

* The information in this tool is aimed at the patient/client/user/person, depending on the context

3

1.2 ADULT PRIMARY CARE

WHAT?	Adult Primary Care (APC) is a symptom-based integrated clinical management tool using a series of algorithms and checklists.
WHY?	The APC is intended to guide the management of common symptoms and chronic conditions in adults
WHEN?	APC has been developed using the approved clinical policies and guidelines issued by the National Department of Health. Should be used during the management of patients.
HOW?	This guide is combined with short on-site training sessions, repeated over several months to allow primary healthcare practitioners to integrate recommendations into their clinical practice, and feedback experiences.
WHO?	It is intended for use by all healthcare practitioners working at primary care level in South Africa.

adult primary care

Symptom-based integrated approach to the adult in primary care

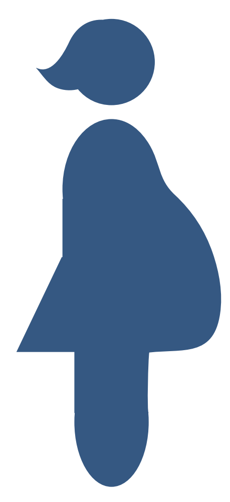
TB
HIV
ASTHMA/COPD
CARDIOVASCULAR DISEASE
DIABETES
MENTAL HEALTH CONDITIONS
EPILEPSY
MUSCULOSKELETAL DISORDERS
WOMEN'S HEALTH

health
Department: Health
REPUBLIC OF SOUTH AFRICA

2016/2017

PREFACE

1.3. MATERNAL CARE



WHAT?	The Guidelines for Maternal Care in South Africa are evidence based management principles to be used by doctors and midwives providing obstetric and anaesthetic services to pregnant mothers.
WHY?	To assist practitioners in the management of pregnant patients in order to improve quality of care and reduce mortality.
WHEN?	Should be used during consultation with pregnant patients.
HOW?	As a document that guides the development of facility specific protocols based on each facilities unique circumstances.

GUIDELINES FOR MATERNITY CARE IN SOUTH AFRICA

Fourth Edition

2015

National Department of Health, Republic of South Africa

OBJECTIVE OF THE NATIONAL GUIDELINES

These guidelines have been prepared by the Sub directorate: Maternal Health for the guidance of health workers (doctors and midwives) providing obstetric, surgical and anaesthetic services for pregnant women in district clinics, health centres and district hospitals.

In the absence of a functioning system of primary health care and without guidance for clinical management and referral, pregnancy related deaths and ill health could be expected to continue at unacceptably high rates.

USING THESE GUIDELINES

FORMAT AND CONTENT

These guidelines are intended for use in clinics, community health centres and district hospitals where specialist services are not normally available. The guidelines deal mainly with the diagnosis and especially the management of common and serious pregnancy problems. The assumption is made that the reader has a basic knowledge and understanding about the care of pregnant women. With a few exceptions (e.g. pre-eclampsia), there is no mention of aetiology and pathogenesis of the conditions described.

The emphasis is on the **practical identification and correct management of problems**, including referral to higher levels of care. The approach is unashamedly dry, and reduced to point format, so that a management plan can be quickly assimilated and enacted. For certain clinical problems, algorithms (flow diagrams) have been prepared.

The guidelines are based on the best available evidence from published research, modified where necessary to suit local conditions. References are not given, but are available from the authors on request. Specifics of management and drug dosing are not cast in stone, and can be modified according to the experience and new evidence.

Each patient is an individual and may not necessarily be served best by the suggested guidelines. The guidelines would be used most effectively if individual hospitals and community health centres drew up their own protocols based on the contents, adjusted to their own particular circumstances.

EXCLUSIONS

Detailed guidelines on the following have been excluded from these guidelines:

- **The role of community based resources.** This includes community health workers, doulas (birth supporters), traditional birth attendants and support groups.
- **Technical descriptions of procedures.** Surgical techniques, ultrasound, amniocentesis, etc. cannot be learned from a book. Emergency procedures such as breech delivery are however described.
- **Neonatal care.** Only immediate care of the new-born is described.

1.4. NEWBORN CARE

WHAT?	The Newborn Care Charts are guidelines on the routine care to be provided to *all babies* at birth.
WHY?	To provide guidance for primary care practitioners on routine management of babies.
WHEN?	To manage babies from birth to the time of discharge home or transfer of a sick or small baby to the neonatal unit.
HOW?	Use the Management of the Sick and Small New-born charts to provide care in the neonatal unit of your hospital by following the colour codes- Urgent treatment required and admission to neonatal unit Specific care and treatment now Routine care, once complete baby can be discharged home.

NEWBORN CARE CHARTS

ROUTINE CARE AT BIRTH AND
MANAGEMENT OF THE SICK AND SMALL NEWBORN IN HOSPITAL

Guidelines for the care of all newborns in District Hospitals, Health Centres and Midwife Obstetric Units in South Africa

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

MARCH 2014

MANAGEMENT OF NEWBORNS: ROUTINE CARE AT BIRTH

HELP BABY BREATHE AT BIRTH → TRIAGE → SICK OR SMAL
ROUTINE CARE

MANAGEMENT OF SICK AND SMALL NEWBORNS

ASSESS AND CLASSIFY | TREAT, OBSERVE AND CARE | COUNSEL | DISCHARGE | FOLLOW-UP

Assess need for emergency care — If present — EMERGENCY TREATMENT until stable

Assess for respiratory distress

Assess for priority signs

Assess for injuries, abnormalities or local infections

Check risk factors and special treatment needs

Principles of newborn care
- Maintain normal body temperature
- Administer oxygen if needed
- Maintain normal glucose
- Manage feeds and fluids
- Infection prevention and control
- Transfer and referral

Treat specific conditions
- Apnoea and respiratory distress
- Preterm and low birth weight
- Assess feeding and weight gain in low birth weight babies
- Serious acute infection
- Neonatal encephalopathy
- Neonatal seizures
- Neonatal jaundice
- Congenital abnormalities
- Congenital Syphilis
- Congenital Tuberculosis
- HIV-affected mothers and babies
- Care of HIV infected babies

Counsel
- Baby's illness
- Feeding
- When to return

- Discharge
- Follow up
  - Day 3
  - 6 weeks

Follow up low birth weight and high risk babies
- 3 days after discharge
- 2 weekly until 2.5kg
- 4 months
- 9 months

THE FIRST VISIT (HOW, WHAT, WHY)

HOW	WHAT	WHY – IDENTIFY SPECIAL CONDITIONS OR RISK FACTORS FOR REFERRAL
Ask	Personal history Name	Identify special conditions or risk factors for referral
	Age	<16 or >37 years high risk. Refer to genetic counselling for >37 years
	Address and telephone or cell number	Contact
	Relationship with father of child	
	Tobacco and alcohol use	Tobacco – increased risk growth restriction, abruptio placentae Alcohol – Fetal alcohol syndrome
	Housing	Support system
	Sanitary conditions	Hygiene possible
	Energy source	Storage medication
	Literate Income, occupation	Information given to woman – written or verbal Resources available,
	Obstetric history	Identify special conditions or risk factors for referral
	Number previous pregnancies	More than 5 pregnancies
	Year, gestational age at birth of baby, sex, birth weight	Low birth weight (<2500g), growth-restricted, pre-term (<34 weeks), macrosomic (>4500g)
	Method of delivery (obstetric operations)	Previous caesarean section Previous assisted delivery
	Outcome (live, miscarriage, IUD, ENND, LND, infant deaths)	Risk for current pregnancy. If any deaths – refer
	Special maternal complications Special perinatal (fetal and newborn) complications	Recurrent early abortion, thrombosis, embolus, hypertension, pre-eclampsia, eclampsia, abruptio placentae, placenta praevia, breech or transverse presentation, obstructed labour, third-degree tears, third stage excessive bleeding, puerperal sepsis, post-partum depression – refer Multiple pregnancy, malformed or abnormal child, Rhesus-antibody affection, resuscitation or other treatment of newborn - refer
	Gestational age history	Calculate EDD
	First day of last normal menstrual period (LNMP)	Calculate gestational age
	Cycle, regular/irregular, duration	Reliability of LNMP to calculate gestational age
	Previous contraception, type	Determine 'washout' period
	When contraception stopped	Reliability of LNMP to calculate gestational age
	When and how pregnancy was confirmed	Help with estimation of gestational age
	Sonar in this pregnancy Future plans for pregnancies	Accurate gestational age Introduction to contraceptive use after current pregnancy and what contraceptive method would be appropriate
	Medical history	Identify special conditions or risk factors for referral
	Specific conditions: hypertension, heart, kidney, diabetes, epilepsy, asthma, (TB	High risk pregnancy - refer
	HIV-infected	Stage, ART, PMTCT, viral load, adherence, other medication
	Medication	Severity of medical condition, teratogenic drugs
	Operations other than C/S	Might indicate high risk
	Allergies	Penicillin allergy
	Family history: twins, diabetes, congenital abnormality Current cough, no weight gain, night sweats, fever	Risk for current pregnancy, might need referral Symptom screen for TB, for sputum test

HOW	WHAT	WHY – IDENTIFY SPECIAL CONDITIONS OR RISK FACTORS FOR REFERRAL
Look, feel, listen (Physical Examination)		Identify special conditions or risk factors for referral
	Record weight and height; mid-upper arm circumference (MUAC)	Body mass index (weight (kg)/height(m)2) - refer if BMI <18.5 or>32.3 kg/m2 (malnutrition or overweight); MUAC <23 or ≥33 cm
	Measure blood pressure	Hypertension - refer
	Check general condition, pale, malnourished, jaundiced, short of breath, etc.	Anaemia, chronic disease - refer
	Thyroid mass Breasts	Thyroid lump high risk - refer Ability to breast feed
	Chest and heart auscultation	Heart or lung lesions - refer
	Feel for uterus (if palpable measure height in centimetres Look for abdominal scars, especially caesarean section scars Consider vaginal examination using a speculum	Correlate with estimated gestational age calculated from LNMP - if don't correlate refer for sonar If 30 years or more with no cervical smear, or suspect STI
Tests		Identify special conditions or risk factors for referral
	Test urine: protein, nitrites, leucocytes, glucose	Pre-eclampsia, urinary tract infection, diabetes
	Haemoglobin	Anaemia
	Rapid Rh test	Rhesus iso-immunisation
	RPR	Syphilis
	HIV counselling and testing	Positive – ART. Negative – lifestyle, condoms, bring partner for testing Early detection of adherence issues or HIV resistance to drugs
Plan		Determine level of antenatal care
	Classify for BANC or referral Clinic Checklist	 Check that nothing overlooked
Implement		Preventing complications
	Iron and folate supplements to all women	Prevent anaemia
	Calcium supplementation to all women	Prevent hypertension and pre-eclampsia
	Tetanus toxoid: booster or first injection	Prevent neonatal tetanus
	RPR positive – treat for syphilis	Prevent congenital syphilis and stillbirths
	Rh negative send Coombs test or refer	Prevent rhesus iso-immunisation or refer for treatment
	HIV-infected – start ART	Improve woman's health and pregnancy outcome for infant
	In malaria endemic areas: sulphadoxine/ pyrimethamine	Prevent malaria
	Refer high-risk cases – see checklist	Improve pregnancy outcome
Give advice		Preventing complications and improve general health
	Safe sex and partner HIV testing	Prevent STIs and HIV infection
	Stop tobacco, alcohol	Prevent fetal alcohol syndrome, growth restriction, abruptio placentae
	Infant feeding	Discuss options if HIV-infected, promote exclusive breast feeding
	Education about haemorrhage & warning signs Birth plan	Educate woman Where (what institution) she will give birth, arrangements for transport when goes she into labour
Questions and answers	Give time for free communication	May raise issues that are worrying woman or things left out
Schedule next visit	Write on antenatal record and clinic checklist	
Complete records	Complete clinic record	Checklist helps to prevent things being overlooked
	Complete antenatal care and give it to the woman	Patient carried record is far more effective than clinic held notes

SOURCE: BASIC ANTENATAL CARE PLUS –STANDARD OPERATING PROCEDURES, NATIONAL DEPARTMENT OF HEALTH

FOLLOW-UP VISITS (HOW, WHAT, WHEN WHY)

How	What	When							Why
Rapid assessment and management (RAM)									Act immediately if there is an emergency
Ask:		**20**	**26**	**30**	**34**	**36**	**38**	**40**	
	How are you?	x	x	x	x	x	x	x	
	Is the baby moving?	x	x	x	x	x	x	x	
	Have you had any bleeding?	x	x	x	x		x		
	Have you any concerns/symptoms of?	x	x	x	x	x	x	x	
	Vaginitis								Risk of ascending infections
	Urinary tract infection								Risk of ascending infections
	Cough, weight loss, night sweats, fever								Tuberculosis, other chest infections
	Malnutrition								Chronic disease, poverty
	HIV/AIDS								Ensure proper management
Check antenatal record									
	Calculate current gestational age	x	x	x	x	x	x	x	Check fetal growth and confirm at 40 weeks
	Syphilis serology	x	x	x	x	x	x	x	Check result and treat if necessary
	Haemoglobin	x	x	x	x	x	x	x	Check result and treat for anaemia if Hb low
	HIV counselling and testing	x	X	x	x	x	x	x	Check if retested, start ART if HIV-infected
	HIV/AIDS care and monitoring	x	x	x	x	x	x	x	Monitor viral load as per guidelines
	Booster dose Tetanus toxoid			x					Only if immunising for the first time
	Previous visits concerns	x	x	x	x	x	x	x	Have these been solved?
Look, feel, listen									
	Pallor	x	x	x	x		x		Screen for anaemia, repeat Hb 30 & 38 weeks
	Blood pressure	x	x	x	x	x	x	x	Screen for hypertension
	Urine; protein/glucose	x	x	x	x	x	x	x	Screen for pre-eclampsia and diabetes
	Uterine growth	x	x	x	x		x		Screen for IUGR
	Fetal presentation				x		x		Screen for abnormal lie, e.g. breech

How	What	When							Why
		20	26	30	34	36	38	40	
Signs		x	x	x	x	x	x	x	Note all the abnormalities
Classify		x	x	x	x	x	x	x	Classify the abnormalities into diseases
Treat and advise		x	x	x	x	x	x	x	Treat and advise according to the diseases identified.
Fill in antenatal record and revise birth plan if needed		x	x	x	x	x	x	x	
Implement interventions	Iron and folate supps for all women	x	x	x	x		x		To prevent anaemia
	Calcium supplements for all women	x	x	x	x		x		To prevent hypertension
	Tetanus toxoid booster or first injection								To prevent neonatal tetanus
	RPR positive – treat for syphilis	x	x	x	x	x	x	x	To prevent congenital syphilis and stillbirths
	Rh negative send Coombs test or refer								To identify Rh iso-immunisation
	HIV infected – start/continue ART	x	x	x	x	x	x	x	To support, treat and prevent transmission
	In malaria endemic areas: sulphadoxine/pyrimethamine	x	x	x	x		x		
General advice	Safe sex	x	x	x	x		x		Prevent STIs
	Stop tobacco, alcohol	x	x	x	x		x		Prevent IUGR and congenital abnormalities
	Infant feeding advice	x	x	x	x		x		Plan for feeding choice and reduce MTCT
	Plan for haemorrhage or warning signs	x	x	x	x		x		Early identification of complications
	Birth plan	x	x	x	x	x	x	x	Make sure that an appropriate institution for delivery is identified and that there is a transport plan to get there
	Contraceptive advice	x	x	x	x		x	x	Plan for future pregnancies and space children
Questions and answers		x	x	x	x	x	x	x	Enable woman to voice concerns
Date next follow-up visit		x	x	x	x	x	x	x	
Maintain complete records		x	x	x	x	x	x	x	Ensure antenatal care and clinic checklist completed

SOURCE: BASIC ANTENATAL CARE PLUS –STANDARD OPERATING PROCEDURES, NATIONAL DEPARTMENT OF HEALTH

1.5. INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS

WHAT?

These Guidelines facilitate the use of the IMCI case management process in practice and describes a series of all the case management steps in a form of IMCI charts.

WHO?

The IMCI chart booklet is for use by doctors, nurses and other health professionals who see young infants and children less than five years old.

WHEN?

The IMCI chart booklet should be used by all health professionals when providing care to sick children to help them apply the IMCI case management guidelines.

HOW?

These charts show the sequence of steps and provide information for performing them. The chart booklet is divided into two main parts because clinical signs in sick young infants and older children are somewhat different and because case management procedures also differ between these age groups.

WHO?

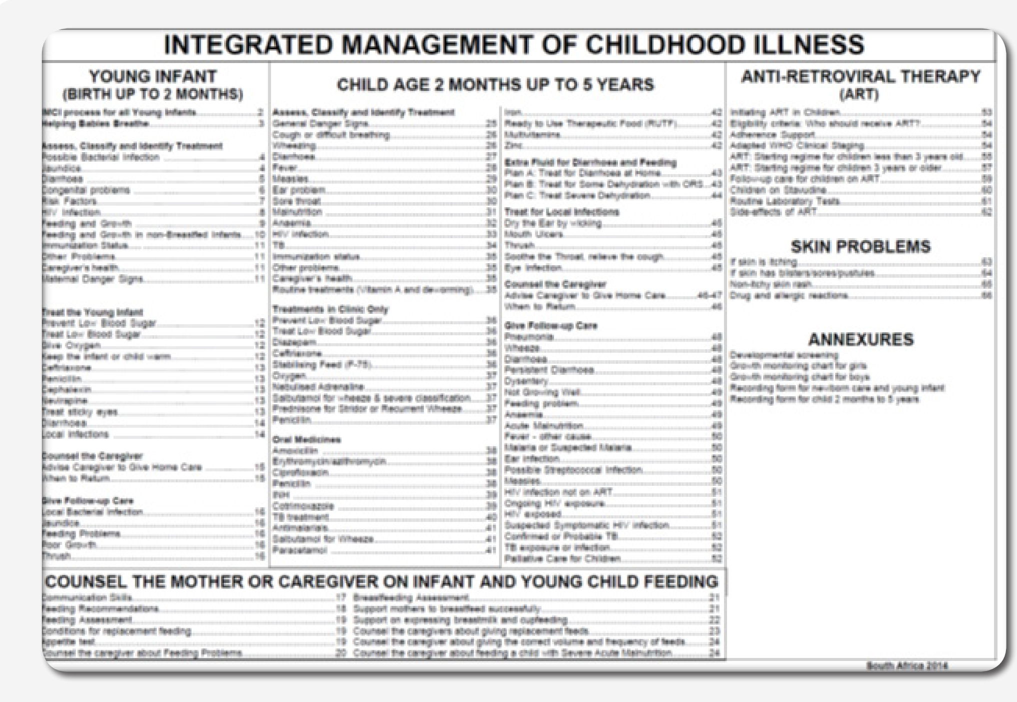
Sick child aged 2 months to 5 years

This part contains all the necessary clinical algorithms, information and instructions on how to provide care to sick children aged 2 months to 5 years.

Sick young infant aged up to 2 months

This part includes case management clinical algorithms for the care of a young infant aged up to 2 months.

Each of these parts contains IMCI charts corresponding to the main steps of the IMCI case management process.



INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS

YOUNG INFANT (BIRTH UP TO 2 MONTHS)

IMCI process for all Young Infants 2
Helping Babies Breathe 3

Assess, Classify and Identify Treatment
Possible Bacterial Infection 4
Jaundice 4
Diarrhoea 5
Congenital problems 6
Risk Factors 7
HIV Infection 8
Feeding and Growth 9
Feeding and Growth in non-Breastfed Infants 10
Immunization Status 11
Other Problems 11
Caregiver's health 11
Maternal Danger Signs 11

Treat the Young Infant
Prevent Low Blood Sugar 12
Treat Low Blood Sugar 12
Give Oxygen 12
Keep the infant or child warm 12
Ceftriaxone 13
Penicillin 13
Cephalexin 13
Nevirapine 13
Treat sticky eyes 13
Diarrhoea 14
Local infections 14

Counsel the Caregiver
Advise Caregiver to Give Home Care 15
When to Return 15

Give Follow-up Care
Local Bacterial Infection 16
Jaundice 16
Feeding Problems 16
Poor Growth 16
Thrush 16

CHILD AGE 2 MONTHS UP TO 5 YEARS

Assess, Classify and Identify Treatment
General Danger Signs 25
Cough or difficult breathing 25
Wheezing 26
Diarrhoea 27
Fever 28
Measles 29
Ear problem 30
Sore throat 30
Malnutrition 31
Anaemia 32
HIV infection 33
TB 34
Immunization status 35
Other problems 35
Caregiver's health 35
Routine treatments (Vitamin A and deworming) 35

Treatments in Clinic Only
Prevent Low Blood Sugar 36
Treat Low Blood Sugar 36
Diazepam 36
Ceftriaxone 36
Stabilising Feed (F-75) 36
Oxygen 37
Nebulised Adrenaline 37
Salbutamol for wheeze & severe classification 37
Prednisone for Stridor or Recurrent Wheeze 37
Penicillin 37

Oral Medicines
Amoxicillin 38
Erythromycin/azithromycin 38
Ciprofloxacin 38
Penicillin 38
INH 39
Cotrimoxazole 39
TB treatment 40
Antimalarials 41
Salbutamol for Wheeze 41
Paracetamol 41
Iron 42
Ready to Use Therapeutic Food (RUTF) 42
Multivitamins 42
Zinc 42

Extra Fluid for Diarrhoea and Feeding
Plan A: Treat for Diarrhoea at Home 43
Plan B: Treat for Some Dehydration with ORS 43
Plan C: Treat Severe Dehydration 44

Treat for Local Infections
Dry the Ear by wicking 45
Mouth Ulcers 45
Thrush 45
Soothe the Throat, relieve the cough 45
Eye Infection 45

Counsel the Caregiver
Advise Caregiver to Give Home Care 46-47
When to Return 46

Give Follow-up Care
Pneumonia 48
Wheeze 48
Diarrhoea 48
Persistent Diarrhoea 48
Dysentery 48
Not Growing Well 49
Feeding problem 49
Anaemia 49
Acute Malnutrition 49
Fever - other cause 50
Malaria or Suspected Malaria 50
Ear infection 50
Possible Streptococcal Infection 50
Measles 50
HIV infection not on ART 51
Ongoing HIV exposure 51
HIV exposed 51
Suspected Symptomatic HIV infection 51
Confirmed or Probable TB 52
TB exposure or infection 52
Palliative Care for Children 52

ANTI-RETROVIRAL THERAPY (ART)

Initiating ART in Children 53
Eligibility criteria: Who should receive ART? 54
Adherence Support 54
Adapted WHO Clinical Staging 54
ART: Starting regime for children less than 3 years old 55
ART: Starting regime for children 3 years or older 57
Follow-up care for children on ART 59
Children on Stavudine 60
Routine Laboratory Tests 61
Side-effects of ART 62

SKIN PROBLEMS

If skin is itching 63
If skin has blisters/sores/pustules 64
Non-itchy skin rash 65
Drug and allergic reactions 66

ANNEXURES

Developmental screening
Growth monitoring chart for girls
Growth monitoring chart for boys
Recording form for newborn care and young infant
Recording form for child 2 months to 5 years

COUNSEL THE MOTHER OR CAREGIVER ON INFANT AND YOUNG CHILD FEEDING

Communication Skills 17
Feeding Recommendations 18
Feeding Assessment 19
Conditions for replacement feeding 19
Appetite test 19
Counsel the caregiver about Feeding Problems 20
Breastfeeding Assessment 21
Support mothers to breastfeed successfully 21
Support on expressing breastmilk and cupfeeding 22
Counsel the caregivers about giving replacement feeds 23
Counsel the caregiver about giving the correct volume and frequency of feeds 24
Counsel the caregiver about feeding a child with Severe Acute Malnutrition 24

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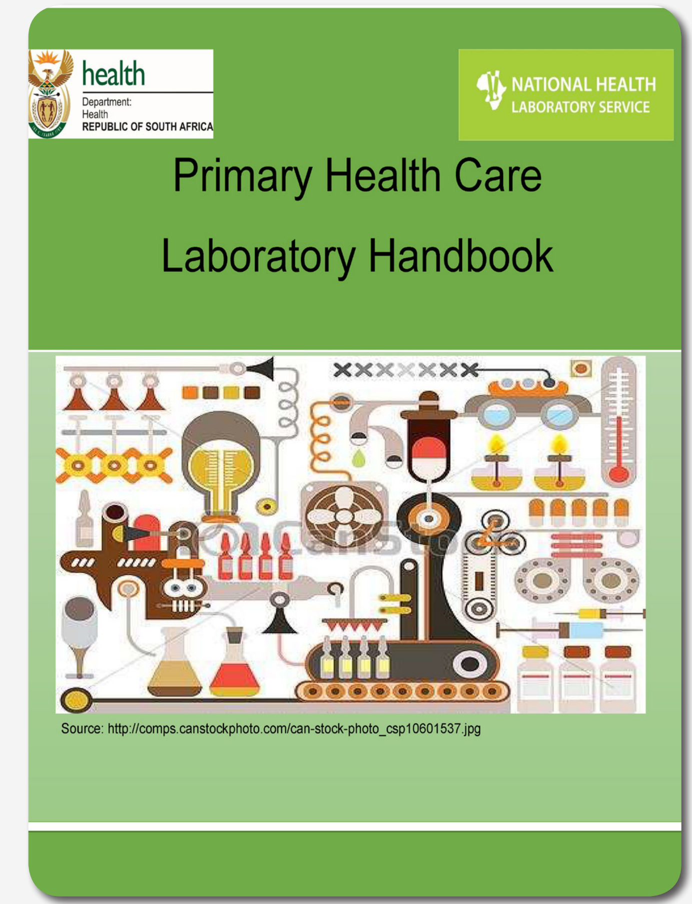
1.6. PRIMARY HEALTHCARE LABORATORY HANDBOOK

WHAT?	The Lab Handbook is a step-by-step guide for the process of identifying, collecting and submitting laboratory specimens to the laboratory.
WHY?	To enhance the appropriate use of diagnostic services as part of ICSM. To foster an understanding of appropriate and most cost effective tests that should be performed at the primary healthcare.
WHEN?	During the process of ordering investigations for patients.
HOW?	Review the relevant section of the manual as it pertains to diagnostic services.
WHO?	To be used by nurses and doctors in clinics.



Primary Health Care (PHC) Laboratory Handbook
A step-by-step guide

Overview of the handbook

This handbook has been designed to provide the facility manager with guidance to manage and monitor consistent availability of appropriate laboratory services.

This handbook provides a step-by-step guide for the process of identifying, collecting and submitting laboratory specimens by primary health care (PHC) facilities to their local NHLS laboratory. It has been developed to enhance the appropriate use of the diagnostic laboratory services as part of an Integrated Clinical Services Management (ICSM) approach. In addition, it aims to foster an understanding of appropriate, relevant and cost-effective tests that should be performed at the primary health care (PHC) level. The core elements of the handbook are depicted graphically below.

Section 1: Complete Request Form Step-by-Step guide to complete the request form as well as complying with the minimum clinical data set requirements.	**Section 2: Collect Specimen from patient** Step-by-Step guide to collect the various specimens required for the tests identified in the Essential Lab List (ELL).
Section 3: Package Specimen Step-by-Step guide to package the collected patient specimens in the specimen bags after attaching the request form barcode.	**Section 4: Specimen Storage** Step-by-Step guide on the correct storage of patient specimens prior to and after the daily courier collection time/s.
Section 5: Specimen Collection by Courier Step-by-Step guide to preparing specimens for collection by courier.	**Section 6: Results Access** Step-by-Step guide on the different ways to access patient results - from the delivery of printed reports to web-based access.
Section 7: Order Specimen Collection Materials Step-by-Step guide to ordering laboratory request forms and specimen collection materials from your local laboratory.	**Section 8: Access to additional Information** This provides resources for additional information and contact details about laboratory services.

2. CLINICAL GUIDELINE TRAINING

2.1. HEALTH FOR ALL TRAINING

HEALTH FOR ALL *TRAINING SCHEDULE*

FACILITY TRAINERS TRAINING PROGRAMME

DAY 1	TIME
Introduction & Welcome • Why are we here? • What we AIM to achieve • Ground rules	09h00 – 09h30
Introducing the tool	09h30 - 10h10
Pretest	10h10 – 10h30
TEA	10h30 - 11h00
Board Game	11h00 - 11h20
Behavioural Change	11h20 - 11h50
Handout manual	11h50 – 12h00
Practical Use of Manual	12h00 – 12h20
Scenario based training: SBT #1	12h20 - 12h45
Feedback	12h45 - 13h00
LUNCH	13h00 - 13h45
SBT #2 + 3	13h45 - 15h15
Feedback	15h15 - 15h30
TEA	15h30-16h00
SBT # 4 + 5	16h00 - 16h40
Feedback and Wrap Up	16h40 - 17h00
DAY 2	**TIME**
Feedback and Reflections	08h00 - 08h20
Challenges changing behaviour	08h20 - 08h40
SBT # 6 + 7	08h40 - 09h40
Feedback	09h40 – 10h00
TEA	10h00 - 10h30
SBT # 8 + 9 + 10	10h30 - 12h00
Feedback/ Questions & Answers	12h00 – 12h30
Course Evaluation	12h30 – 13h00
LUNCH	13h00 - 14h00
Posttest assessment	14h00 - 14h30
Next steps + Wrap up	14h30 - 15h00

2.2. ADULT PRIMARY CARE TRAINING

The Adult Primary Care (APC) training programme recognises that guidelines alone are insufficient to improve practice. Active implementation is recommended, and this guide is combined with short, on-site training sessions, to be repeated over several months in order to allow PHC practitioners to integrate recommendations into their clinical practice, and feedback experiences.

- Each facility will receive copies of the APC/PC101 for use by professional nurses whilst consulting patients
- At each facility, a single facility trainer will be shown how to train all professional nurses at the facility
- All professional nurses and support staff will be trained on the application of the APC in the management of chronic patients by the facility trainer over the course of twelve weeks to be followed by a maintenance programme to ensure strengthening of clinical care by service providers.
- All staff receive 12 modules of training and a register of training must be completed. Refer to page 31-33 of APC/PC101 guide for training schedule.

ADULT PRIMARY CARE MANUAL *TRAINING SCHEDULE*

» Training format for the initial on-site training sessions

Follow steps		What to do	What you're aiming to achieve
• Welcome	10 min	• Ask the facility staff how they are doing since you last met. • Remind about commitment to group e.g. cell phones off, stay the duration, contribute cases, have fun etc. • Introduce topic for the session using an icebreaker/relevant piece of information, etc. • Choose a time-keeper for the session.	• Facility staff feel involved and that they own the training. • Get everyone focused on being in the training session.
• Recap • Problem solve	20 min	• Ask about Primary Care 101 - what's working/ not working? Are there clinical questions or systems problems? • Make a record of issues to share with your Master Trainer. • Use PC 101 to work out cases by using the folders brought to the session by you or by other staff members.	• Identify problems with systems or use of PC 101 and try to solve them. • Establish whether the guideline is being used with ease in clinical practice. • A sense that clinical practice has become more satisfying.
• Train new topic	55 min	• Being prepared and structured will help you feel confident. • Use case format: be systematic, following the case template.	• Cover the guideline content planned for the session.
• Prepare for next session • Closure	5 min	• Get group to summarise session. • Tie up loose ends • Plan next session: - Ask facility staff to bring patient folders, problems. - Set date and time. • Close with song, prayer – whatever the norm for your group.	• Celebrate use of PC 101! • Ensure continuity of and commitment to training sessions.

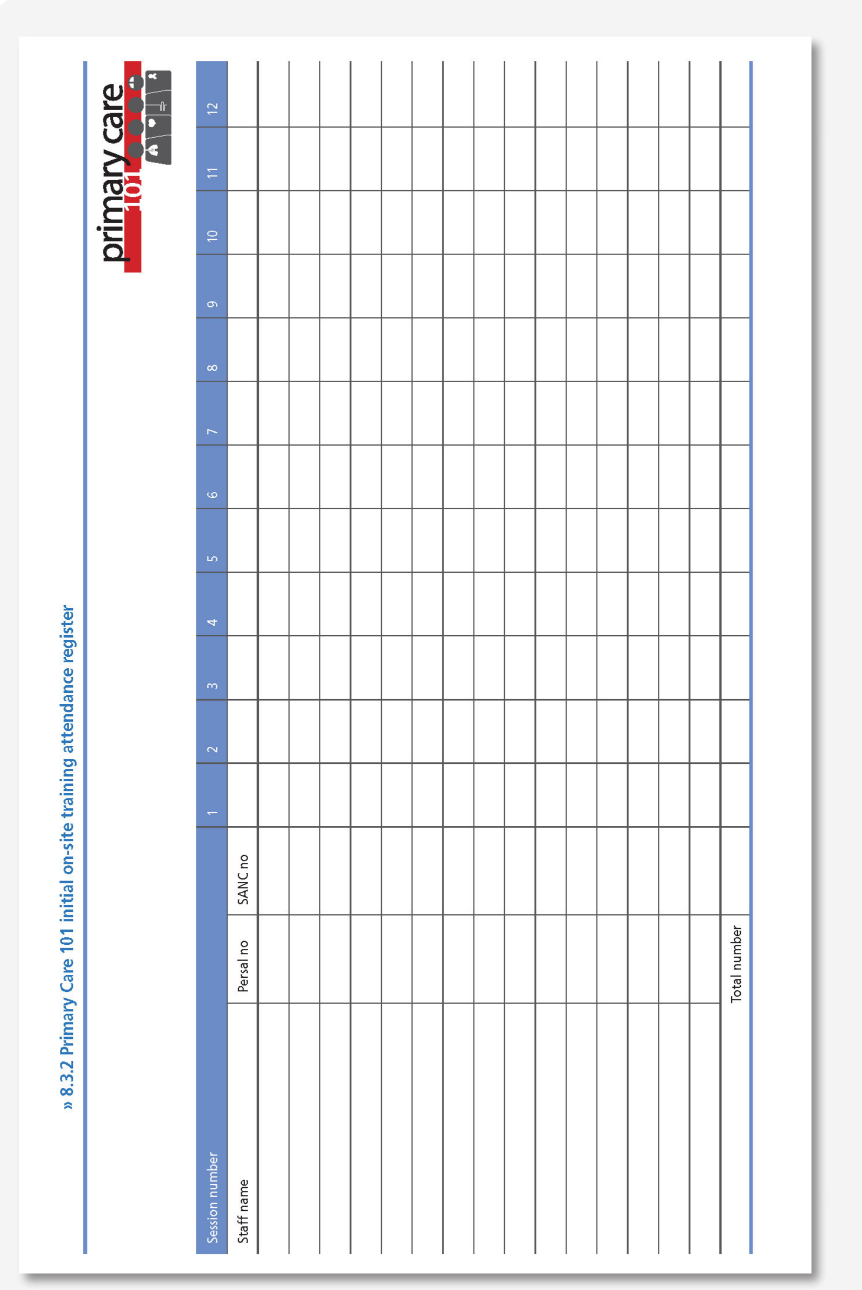
» Clinical content for the 12 initial on-site training sessions

Training session	Topic	Case (case number)
1	• Introduction to PC 101 • Introductory game • Approach to symptoms: - Patient needing urgent attention: seizure - Using an algorithm - 2 symptoms	Faizel (1) Anna (2) Patricia (3)
2	• Checking for chronic condition • Approach to routine care: Assess, Advise, Treat: STI, epilepsy	Godfrey (6) Herman (5), Sophie (4) Faizel (26)
3	• 'Who needs ART?' • HIV routine care	Stanley (7)
4	• TB game • TB: diagnosis and follow-up	Sister Betina (8) Bongani (9)
5	• HIV routine care ART and complications	Nondumiso (10; 13) Rethabile (11) Andreas (14)
6	• Integrating TB and HIV routine care • Occupational infection	Nobantu (15) Rethabile (16)
7	• Pregnancy: routine HIV and antenatal care	Melissa (12)
8	• Chronic respiratory disease • Spacer/inhaler demonstration	Mrs Dube (17) Sophie (18) Auntie Gertie (19)
9	• CVD risk and disease • Prep Room Page Activity	Thobeka (20) Xolani (21) Sipho (22)
10	• Integrating diabetes and hypertension routine care	Caroline (23)
11	• Depression • Substance abuse	Jane (24) Adelaide (25)
12	• Integrating the routine care of the patient with multiple chronic conditions: musculoskeletal condition, CVD risk, substance abuse	Boeta (27)

» Training format for monthly maintenance sessions

Follow steps	Time	What to do	What you're aiming to achieve
• Welcome	10 min	• Ask the facility staff how they are doing since you last met. • Remind about commitment to group e.g. cell phones stay off, stay the duration, contribute, have fun etc. • Remind them that last month you told them that the focus for this month would be .... Where you invited ....to look for patients with that/those conditions. You have received X amount of cases and have chosen to use case X for today. • Choose a time-keeper for the session.	• Facility staff feel involved and that they own the training. • Get everyone focused on being in the training session.
• Recap • Problem solve	20 mins	• **Systems:** Before working through the health focus, check whether systems issues identified last month have been resolved. If not, why not? Identify a dedicated person to take the matter forward through the appropriate channels. If resolved, celebrate! • **Clinical:** Check whether cases/clinical matters that arose at the last session have been addressed and resolved. If not, ensure that a dedicated person will take the clinical issue to the appropriate person for clarification and feedback the answer next month.	• Identify problems with systems or use of PC 101 and try to solve them. • Establish whether the guideline is being used with ease in clinical practice. • A sense that clinical practice has become more satisfying.
• Train the monthly focus session	55 mins	• You would have selected the case(s) to use during this session according to the topic for the monthly training session. • Work through the case(s) systematically using the completed case template form. • Resolve any queries that arise from the case. • Ask the group to summarise the session. • Tie up loose ends.	• Cover the relevant PC 101 content for that month.
• Prepare for next month • Closure	10 mins	• Inform your colleagues of the health topic for next month. • Hand out case templates and select who will be responsible for completing them. • Encourage them to choose challenging and interesting cases. • Set a date to review these cases so that you can ensure that they are relevant to the session and that they add value to the learning and application of PC 101. • Confirm the date, time and venue for the next training session. • Close with a song/ prayer – whatever the norm for your group.	• Set-up cases and date/ time/ venue for next session. • Ensure continuity to and commitment to training sessions. • Celebrate use of PC 101!

A register of the training should be maintained in order to identify all health professionals that have completed the training.



» 8.3.2 Primary Care 101 initial on-site training attendance register

primary care 101

Session number			1	2	3	4	5	6	7	8	9	10	11	12
Staff name	Persal no	SANC no												
	Total number													

2.3. IMCI TRAINING

The IMCI Case Management Programme is a 10 day programme conducted by the Regional Training Centres in collaboration with the National Department of Health. The following is an outline of the training programme.

IMCI PROGRAMME TRAINING SCHEDULE

DAY 1	**DAY 6**
Registration Introduction Module	Practical: Assess Child till HIV box
Module 5 (Young infant Pages 1-21)	Read from TB to the end of Module 2
DAY 2	**DAY 7**
Helping Babies Breathe (HBB)	Continue Module 3 till Page 37 (Treat the child) Finish Treat the child Module (Page 37 - 68)
Helping Babies Breathe practical	Practical Assess till TB box (Ward 6)
Continue Module 5 (page 21 till HIV management)	Day 8
DAY 3	**PRACTICAL ASSESS AND TREAT**
Continue Module 5 (Pages 14-42)	Start counsel The Mother Module (Module 4)
In-patients Practical ward 4	Day 9
DAY 4	**CONTINUE WITH MODULE 4**
Start Module 2 till page 36 (Diarrhoea)	Day 10
Continue module 2 (Fever - Page 53 Ear infection)	RTC Start Follow-up (Module 6)
DAY 5	**FINISH MODULE 6** **WAY FORWARD**
Malnutrition (page 54-66)	
Practical Ward 6 (Assess General Danger Signs till fever)	

3. PATIENT CLINICAL RECORDS

Clinical records include a wide variety of documents generated by, or on behalf of, all health professionals involved in patient care[23].

The main purpose of any clinical record is to provide continuity of care, but medical records are also used for other purposes:

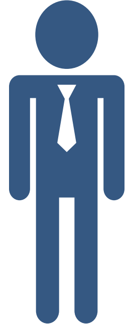
- Administrative and managerial decision-making.
- Meeting current legal requirements, including enabling patients to access their records.
- Assisting in clinical audit.
- Supporting improvements in clinical effectiveness through research.
- Providing the necessary factual basis for responding to complaints and clinical negligence claims.

Standardised clinical stationary has been designed by the National Department of Health for patients.

This allows for a five year longitudinal record for all patients.

3.1. ADULT MALE CLINICAL RECORD

The following thumbnails are examples of clinical records and are not intended to be complete.



ADULT MALE CLINICAL RECORD

Demographic details .... Pg 2
Subsequent changes to demographics detail .... pg 3
Patient profile – first visit ....pg 4-5
Annual review..pg 6-9
ART initiation .... pg 10-11
Clinical management .... pg 12 -25
Oral healthcare .... pg 26-31
Rehabilitation service... pg 32-37
Laboratory test results .... pg 38-41
Prescription .... pg 42-53
TB adherence.. pg 54-61
Consent for HIV and other testing......................... pg 62-64
Consent for HIV and other testing......................... pg 78-80
Pockets for laboratory results and referrals.............. pg 65

TABLE OF CONTENTS

Table of contents indicating composition of male clinical record records.

PATIENT PROFILE - FIRST VISIT

To be completed at first visit

Past Surgical History

Previous operations	Date	Complications

Allergies: Y N Specify:

Sexual Reproductive Health History

Prostate investigation:	Y N	If yes; last date	Y Y Y Y	Result:	
Circumcised	Y N	If yes; last date	Y Y Y Y	If No, comment:	

Date completed: d d m m y y y y

Demographic details to be completed by administrative clerk – similar to child record.

PATIENT PROFILE - FIRST VISIT

To be completed at first visit

Social *(Please Tick)*

Type of employment:	Unemployed	Self-employed	Formally employed		
Living conditions:	Informal dwelling	Formal House	Hostel	Other institutions (specify):	
	Owner	Tenant	Number in household:		
	Piped water inside dwelling	Piped water outside dwelling	Communal tap		
	Borehole	Rain water	Rain/stream water		
	Flushing toilet in house	Flushing toilet outside house	Pit toilet		
	VIP toilet	Bucket system	None		
Cooking method:	Electricity	Gas	Paraffin	Coal	Firewood
Social assistance:	Disability grant	Child support grant	Foster care grant	Pension	

Risk Factors *(Please Tick)*

Alcohol:	Y N	(If Yes)	Type:	Quantity:	Frequency:
Smoking/tobacco:	Y N	(If Yes)	Year Started:	Frequency:	
Other substances:	Y N	Specify:			
Physical activity:	Walk		Run		Active sport
Healthy eating:	Do you run out of food? Y N	Do you eat a heaped plate of food? Y N	Do you eat food high in: Salt? Y N	Do you eat food high in: Fat? Y N	Do you eat food high in: Sugar? Y N
Sexual behavior:	Number of current partners:				
	Have you had multiple partners in the past six months?	Y N			
	Do you protect yourself and your partner every time you have sex?	Y N			
	HCT done?	Y N	Date		

Family History *(Please Tick)*

- Heart Disease
- Hypertension
- Diabetes
- TB
- Mental Health
- Cancer; if yes, specify: ____
- Other; specify: ____

Known Chronic Health Conditions

			Year diagnosed				Current medication/trea...
HIV	Y	N	Y	Y	Y	Y	
TB	Y	N	Y	Y	Y	Y	
Hypertension	Y	N	Y	Y	Y	Y	
Ischaemic heart disease	Y	N	Y	Y	Y	Y	
Diabetes	Y	N	Y	Y	Y	Y	
Asthma/ COPD	Y	N	Y	Y	Y	Y	
Mental Health	Y	N	Y	Y	Y	Y	
Epilepsy	Y	N	Y	Y	Y	Y	
Rheumatic heart disease	Y	N	Y	Y	Y	Y	
Physical Disability; e.g. blindness, limited mobility, etc.	Y	N	Y	Y	Y	Y	
Chemotherapy	Y	N	Y	Y	Y	Y	
Liver disease	Y	N	Y	Y	Y	Y	
Kidney disease	Y	N	Y	Y	Y	Y	
Other; specify	Y	N	Y	Y	Y	Y	

Date completed: d d m m y y y y

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During the patient's first visit a detailed social history is taken.

HPRS Label

DEMOGRAPHIC DETAILS

Allergy sticker

Patient file number:	_ _ _ – _ _ _ – _ _ _ _				
ID/Passport number:					
Name:					
Surname:					
Date of birth:	d d m m y y y y				
Facility name:					
Facility unique number:					
Marital status:	Single	Married	Divorced	Widowed	Cohabitation

RESIDENTIAL ADDRESS

...use number and ...t name:	
...ne	

...ONTACT DETAILS (If employed)

... employer:	
Work address:	
Work telephone number:	

ALTERNATIVE CONTACT DETAILS

Next of kin (name & surname)	
Relationship to patient:	
Home telephone number:	
Cell number:	

Date completed: d d m m y y y y

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PATIENT PROFILE - ANNUAL REVIEW

Update as relevant

Social *(Please Tick)*

Type of employment:	Unemployed	Self-employed	Formally employed
Living conditions:	Informal dwelling	Formal House	Hostel / Other institutions (specify):
	Owner	Tenant	Number in household:
	Piped water inside dwelling	Piped water outside dwelling	Communal tap
	Borehole	Rain water	Rain/stream water
	Flushing toilet in house	Flushing toilet outside house	Pit toilet
	VIP toilet	Bucket system	None
Cooking method:	Electricity	Gas	Paraffin / Coal / Firewood
Social assistance:	Disability grant	Child support grant	Foster care grant / Pension
Date completed:	d d m m y y y y		

Social *(Please Tick)*

Type of employment:	Unemployed	Self-employed	Formally emplo…
Living conditions:	Informal dwelling	Formal House	Hostel
	Owner	Tenant	Numb…
	Piped water inside dwelling	Piped water outside dwelling	Comm…
	Borehole	Rain water	Rain/…
	Flushing toilet in house	Flushing toilet outside house	Pit t…
	VIP toilet	Bucket system	None
Cooking method:	Electricity	Gas	Paraffin
Social assistance:	Disability grant	Child support grant	Foster care…
Date completed:	d d m m y y y y		

Social *(Please Tick)*

Type of employment:	Unemployed	Self-employed	Formally employed
Living conditions:	Informal dwelling	Formal House	Hostel / Other institutions (specify):
	Owner	Tenant	Number in household:
	Piped water inside dwelling	Piped water outside dwelling	Communal tap
	Borehole	Rain water	Rain/stream water
	Flushing toilet in house	Flushing toilet outside house	Pit toilet
	VIP toilet	Bucket system	None
Cooking method:	Electricity	Gas	Paraffin / Coal / Firewood
Social assistance:	Disability grant	Child support grant	Foster care grant / Pension
Date completed:	d d m m y y y y		

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Annual review – Updating of any changes in risk factors.

PATIENT PROFILE - ANNUAL REVIEW

Update as relevant

Risk Factors *(Please Tick)*

Alcohol:	Y N	(If Yes) Type:	Quantity:	Frequency:
Smoking/tobacco:	Y N	(If Yes) Year Started:	Frequency:	
Other substances:	Y N	Specify:		
Physical activity:	Walk	Run	Active sport	
Healthy eating:	Do you run out of food? Y N	Do you eat a heaped plate of food? Y N	Do you eat food high in: Salt? Y N / Fat? Y N	Do you eat food high in: Sugar? Y N
Sexual behavior:	Number of current partners:			
	Have you had multiple partners in the past six months? Y N			
	Do you protect yourself and your partner every time you have sex? Y N			
	HCT done? Y N	Date of last test: d d m m y y y y	Results: Positive / Negative	
Date completed:	d d m m y y y y			

Risk Factors *(Please Tick)*

Alcohol:	Y N	(If Yes) Type:	Quantity:	Frequency:
Smoking/tobacco:	Y N	(If Yes) Year Started:	Frequency:	
…ther substances:	Y N	Specify:		
…ysical activity:	Walk	Run	Active sport	
…ealthy eating:	Do you run out of food? Y N	Do you eat a heaped plate of food? Y N	Do you eat food high in: Salt? Y N / Fat? Y N	Do you eat food high in: Sugar? Y N
…al behavior:	Number of current partners:			
	Have you had multiple partners in the past six months? Y N			
	Do you protect yourself and your partner every time you have sex? Y N			
	HCT done? Y N	Date of last test: d d m m y y y y	Results: Positive / Negative	
Date completed:	d d m m y y y y			

Risk Factors *(Please Tick)*

Alcohol:	Y N	(If Yes) Type:	Quantity:	Frequency:
Smoking/tobacco:	Y N	(If Yes) Year Started:	Frequency:	
Other substances:	Y N	Specify:		
Physical activity:	Walk	Run	Active sport	
Healthy eating:	Do you run out of food? Y N	Do you eat a heaped plate of food? Y N	Do you eat food high in: Salt? Y N / Fat? Y N	Do you eat food high in: Sugar? Y N
Sexual behavior:	Number of current partners:			
	Have you had multiple partners in the past six months? Y N			
	Do you protect yourself and your partner every time you have sex? Y N			
	HCT done? Y N	Date of last test: d d m m y y y y	Results: Positive / Negative	
Date completed:	d d m m y y y y			

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ART INITIATION

To be completed at ART initiation or transfer-in

Transfer-in: Y N

Referral clinic: ______ ART start date: d d m m y y y y

Presents from:	TB Clinic	PMTCT	VCT	Other ART clinic	PHC	In-patient	Correc-tional services	Work	Other

Has patient disclose HIV status Y N

CLINICAL ASSESSMENT: FIRST VISIT AT THIS CLINIC

WHO CLINICAL STAGING:

If the patient has, OR HAS EVER HAD, any of the illnesses below, and none in stage 4, and a CD4 count>350, the patient needs HIV care

If the patient has, OR HAS EVER HAD, any of the illnesses below, and a CD4 count<350, the patient needs ART

WHO stage	Clinical features		WHO stag…		
WHO stage 1	Persistent generalised lymphadenopathy	Y N	WHO sta…	…th	Y N
	Other:	Y N			
WHO stage 2	Weight loss <10% body weight	Y N			
	Minor mucocutaneous conditions	Y N			
	Recurrent URTI	Y N			
	Uncomplicated Herpes Zoste	Y N			
	Other:	Y N			Y N
WHO stage 3	Weight loss >10% body weight	Y N			Y N
	Diarrhoea > 1 month	Y N			Y N
	Oral candidiasis	Y N	Bed… >50%/day …st of last month		Y N
	Severe bacterial infections including Pneumonia	Y N	Cryptococcal meningitis		Y N
	Oral hairy leukoplakia	Y N	Lymphoma		Y N
	Prolonged fever	Y N	Extra-pulmonary TB		Y N
	Bedridden <50%/day most of last month	Y N	Other		Y N
	Pulmonary TB (current or in last year)	Y N	CD4 result		Y N
	Other:	Y N			

NUTRITIONAL ASSESSMENT

Symptoms present: *(Please tick)*	Nausea	Vomitting	Diarrhoea	Severe loss of weight	Difficulty swallowing
Baseline BMI:					

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ART stationery is integrated in the single record.

ART INITIATION

To be completed at ART initiation or transfer-in

HISTORY AND EXAMINATION & PLAN

Screened for IPT:	Y N	Qualifies for IPT:	Y N	Started IPT Date: d d m m y y y y	Y N
Screened for Cotrimoxazole:	Y N	Already on Cotrimoxazole:	Y N	Qualifies/started Cotrimoxazole: Date: d d m m y y y y	Y N
Screened for other/ Fluconazole:	Y N	Qualifies/started other/Fluconazole:	Y N	Qualifies/started other/Fluconazole: Date: d d m m y y y y	Y N
CD4 >350 AND stage 1 – 3	Y N	CD4 <- 350	Y N		

PSYCHO-SOCIAL READINESS

Has patient attended all required counselling sessions?	Y N	Does patient have a treatment buddy?	Y N
Has patient disclosed to anyone?	Y N	Does patient attended the clinic regularly?	

PRE-ART COUNSELLING

Session	Date	Counsellor/group	Treatment buddy attended?	Comments
General HIV Education and Healthy Living			Y N	
Antiretroviral Therapy			Y N	
Adherence Planning			Y N	
Other			Y N	

Name and details for treatment buddy

Patient agreed to home visit? Y N | Name of community health worker: | Attends a support group: Y N

What is clients understanding (in their own words) for wanting ART

BASELINE SAFETY BLOODS

Test	Date	Result	Notes
ALT			
Haemoglobin			
CD4			
Creatinine clearence			
Other:			

CLINICAL FACTORS INFLUENCING REGIMEN CHOICE

On TB treatment	Y N	Has been more than 1 month on ART (excluding PMTCT or PEP)	Y N	PLAN:
Has severe peripheral neuropathy	Y N	BMI > 27.5	Y N	ARV 1
Has a history of psychiatric illness	Y N	Other:		ARV 2
				ARV 3

Next visit in:	weeks
Health Care Practitioner	
Name:	
Surname:	
Signature:	
SANC/HPCSA No:	
Date completed:	d d m m y y y y

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CLINICAL MANAGEMENT

Visit number:	1	2	3
Date of visit:	d d m m y y y y	d d m m y y y y	d d m m y y y y
Vital signs			
Weight:			
Height:			
BMI:			
Temperature:			
Pulse:			
Blood pressure:			
Blood glucose:			
Urine:			
Basic screening			
HIV	Y N	Y N	Y N
TB	Y N	Y N	Y N
STI	Y N	Y N	Y N
Diabetes	Y N	Y N	Y N
Lifestyle risk assessment			
Alcohol:	Y N	Y N	Y N
Smoke/tobacco:	Y N	Y N	Y N
Physical activity:	Y N	Y N	Y N
Healthy eating:	Y N	Y N	Y N
Sexual behaviour:	Y N	Y N	Y N
Known conditions: *(Please tick)*	Heart disease	Hypertension	Asthma/COPD
HIV	Y N		Y N
WHO stage:			
Viral load:			
CD4:			
On ART:	Y N		N
TB:	Intensive phase / Continuation ph		phase
Mental health	Y		N
Adherence to medication and pill count:	Y		N
Side effects to medication:			
Other hospital/doctor visits:			
Additional medication:			
Presenting complaints (Symptoms, duration, severity):			

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Chronic patient record with relevant section for completion at each patient visit.

LABORATORY TEST RESULTS

TEST	Date requested: d d m m y y y y Results	Date requested: d d m m y y y y Results	Date requested: d d m m y y y y Results	Date requested: d d m m y y y y Results
ALP				
ALT				
Calcium				
CD4				
Cholesterol				
Coomb's Test				
CRAG (Cryptococcal antigen test)				
Creatinine (eGFR)				
CPR				
Cytology				
Differential count				
FT4 (Free Thyroxine 4)				
Gamma GT				
Haemoglobin				
HbA1c				
Hepatitis A, B or C				
HIV PCR for infants				
INR				
Lactic Acid				
LDL				
Lipase				
MCS (Non-TB)				
MCV				
Pap smear				
Phenytoin				
Platelets				
Potassium				
PSA				
Red Cell Folate				
RPR				
Sodium				
Stool parasites				
TB Drug Susceptibility				
TB Line Probe Assay				
TB MC&S (re-treatment and HIV patients)				
Triglycerides				
TSH				
Uric Acid (Serum)				
Urine albumin: creatinine ratio				
Urine protein: creatinine ratio				
Viral load				
Vitamin B12				
WBC				
Xpert MTB/RIF				
Other				

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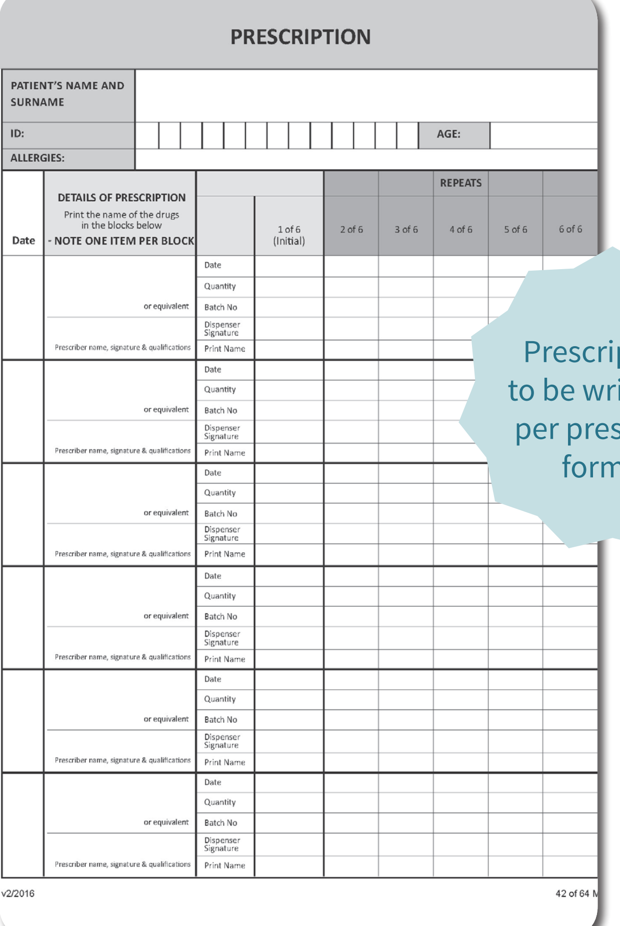
Complete list of laboratory investigations that can be conducted with relevant section for results.



PRESCRIPTION

PATIENT'S NAME AND SURNAME	
ID:	AGE:
ALLERGIES:	

Date	DETAILS OF PRESCRIPTION Print the name of the drugs in the blocks below - NOTE ONE ITEM PER BLOCK		1 of 6 (Initial)	REPEATS 2 of 6	3 of 6	4 of 6	5 of 6	6 of 6
	or equivalent	Date						
		Quantity						
		Batch No						
		Dispenser Signature						
	Prescriber name, signature & qualifications	Print Name						
	or equivalent	Date						
		Quantity						
		Batch No						
		Dispenser Signature						
	Prescriber name, signature & qualifications	Print Name						
	or equivalent	Date						
		Quantity						
		Batch No						
		Dispenser Signature						
	Prescriber name, signature & qualifications	Print Name						
	or equivalent	Date						
		Quantity						
		Batch No						
		Dispenser Signature						
	Prescriber name, signature & qualifications	Print Name						
	or equivalent	Date						
		Quantity						
		Batch No						
		Dispenser Signature						
	Prescriber name, signature & qualifications	Print Name						
	or equivalent	Date						
		Quantity						
		Batch No						
		Dispenser Signature						
	Prescriber name, signature & qualifications	Print Name						

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Prescriptions to be written as per prescribed format.

TB ADHERENCE

If patient was not diagnosed on sputum, indicate other method of diagnosis:

CSF | X-Ray | Aspiration/Biopsy | Mantoux: ....mm

Patient Category:

N New patient
RC Relapse (retreatment after cure)
RF Re-treatment after failure
RD Retreatment after default
OR All other Re-treatment cases not included in above categories

Classification of Disease:

ICD10 Code (According to list in back of TB register) ____________

Pulmonary TB | Both
Extra PTB | Site Extra PTB ____________

Multidisciplinary team:

Placed out: Y N

If no, reason: ____________

Self-Supervised	Workplace	Clinic

Name of Community Health Worker:

Date: d d m m y y y y

Treatment

Intensive Phase (IP)

Drug:	RHZE	60/60	Z	E	Other
Dosage:					

Body weight at start of IP:

Month	Date	No of Doses taken

✓ = patient took medication
✗ = patient did not take medication
— = medication collected for self administration or supervision elsewhere

Health Care Practitioner

Name:
Surname:
Signature:
SANC/HPCSA No:

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TB ADHERENCE

Continuous phase (CP)

Drug:	RHZE	60/60	Z	E	Other
Dosage:					

Body weight at start of CP:

Month	Date	No of Doses taken

✓ = patient took medication
✗ = patient did not take medication
— = medication collected for self administration or supervision elsewhere

TREATMENT SUPERVISOR

Name: ____________ Tel/Cellphone: ____________

Address: ____________

Close Contacts

	Age	Screened		IPT started		TB treatment started	
		Y	N	Y	N	Y	N
		Y	N	Y	N	Y	N
		Y	N	Y	N	Y	N
		Y	N	Y	N	Y	N
		Y	N	Y	N	Y	N

Treatment Outcomes

Treatment stop date: d d m m y y y y

Outcome:	Cured	Treatment completed	Treatment defaulted	Treatment failure	Died

Cured – Patient initially smear -ve at or 1 month prior to completion of treatment & on at least one previous occasion
Treatment completed – Patient has completed treatment but does not have bacteriological proof of cure
Defaulted treatment – Patient whose treatment is interrupted for 2 consecutive months or more
Failed treatment – Patient who remained smear+ at 5 months during treatment
Died – Patient who died for any reason during TB treatment

Referrals

Moved (Patient moved to another facility in the same sub-district)
Transferred out (Patient transferred to another sub-district, district, province)

Facility: ____________ Sub-district/District: ____________
...e: ____________ Country: ____________

...are Practitioner

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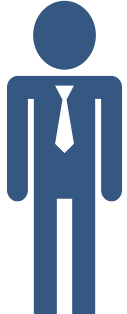
Adult TB record is integrated in the main record so practitioners can track patient treatment and outcomes



3.2. FEMALE CLINICAL RECORD

The following thumbnails are examples of clinical records and are not intended to be complete.

FEMALE CLINICAL RECORD

Demographic details .... Pg 2
Subsequent changes to demographics detail .... pg 3
Patient profile – first visit ....pg 4-5
Annual review...pg 6-9
ART initiation... pg 10-11
Clinical management .... pg 12 -25
Oral healthcare .... pg 26-40
Rehabilitation service... pg 41-47
Laboratory test results .... pg 48-51
Prescription .... pg 52-55
TB adherence .... pg 56-67
Consent for HIV and other testing......................... pg 68-77
Consent for HIV and other testing......................... pg 78-80
Pockets for laboratory results and referrals.............. pg 81

TABLE OF CONTENTS

Table of contents indicating composition of male clinical record records.

The female clinical stationery has antenatal components included in addition to all the clinical aspects contained for males

A complete antenatal clinical record is included – first and subsequent visits

BASIC ANTENATAL CARE ASSESSMENT - FIRST VISIT AND OUTCOME OF PREGNANCY

Complete this form the first time a pregnant woman presents for antenatal care for the pregnancy

Risk Screening		
Age < 16	Y	N
Age > 40 years	Y	N
Previous still birth or neonatal loss?	Y	N
History of 3 or more consecutive spontaneous abortions	Y	N
Birth weight of last baby < 2500g?	Y	N
Birth weight of last baby > 4500g?	Y	N
Last pregnancy: hospital admission for hypertension or pre-eclampsia/eclampsia?	Y	N
Diastolic blood pressure 90 mmHg or more at booking		N
Known 'substance' abuse (including heavy alcohol drinking)		
Any other severe ongoing disease or condition? e.g HT		
Vaginal bleeding		
Diagnosed or suspected multiple pregnancy		
Isoimmunisation Rh (-) previous pregnancy		
Previous surgery on reproductive tract		
IF YES, PLEASE SPECIFY:		
If one risk factor is identified above, refer patient to a higher level of care.		

Investigations:

Pap Smear done: Y N Date: d d m m y y y y Result:
Rapid syphilis test: Pos Neg Repeat syphilis te
RPR (titre): TPHA:
Rhesus: Antibodies:
Creatine: ALT:
Haemoglobin: g/dl Blood pressure: Results:
Tetanus toxoid (date given): 1st: d d m m y y y y 2nd: d d m m y y y y 3rd: d d m m y y y y

Management plan:	
Risk level identified:	
Health education given:	
Treatment prescribed:	
Unit identified for delivery	
Date of next visit:	

GENERAL MEDICAL AND SOCIAL INFORMATION: REFER TO PATIENT PROFILE

Referred to:

Date: d d m m y y y y

Health Care Practitioner	
Name:	
Surname:	
Signature:	
SANC/HPCSA No:	

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BASIC ANTENATAL CARE ASSESSMENT - FIRST VISIT AND OUTCOME OF PREGNANCY

Complete this form the first time a pregnant woman presents for antenatal care for the pregnancy

Obstetric History

Year	Gestation age	Delivery mode NV=Normal Vaginal FS=Forceps VE=Vacuum Extraction CS=Caesarean Section	Weight	Pregnancy outcome A = Alive ID = Infant death NND = Neonatal death IUD = Intra-uterine Death

Previous Obstetric and Family History:

Twins: Y N Genetic conditions: Y N Congenital defects: Y N Diabetes: Y N Hypertension: Y N Intra-uterine growth retardation Y N
Antepartum haemorrhage: Y N Post partum haemorrhage: Y N Preterm labour: Y N Other: (Specify)

Gestational Age:

LMP: Certain? Y N
Expected date of delivery: d d m m y y y y

Examination:

Thyroid:		MUAC:	
Urine:		BMI	
Lungs:		Heart:	
Length:		Breasts:	
Weight:		Other:	

Abdomen:

FHH Measurement: cm Correlates with dates? Y N
Lie: Presentation:

Vaginal Examination: Done Not done

Vulva and Vagina
Cervix
Uterus

HIV Status

Known HIV positive at booking Y N
If Yes (Please tick) Never on ART Currently on ART Previously on ART
If currently on ART: Viral load Regimen:
If previously on ART; Defaulted Y N
If Yes, date last on ART: Date: d d m m y y y y Regime
HIV test done today: Y N Results: POS NEG
CD4 Count CPT Y N IPT Y N

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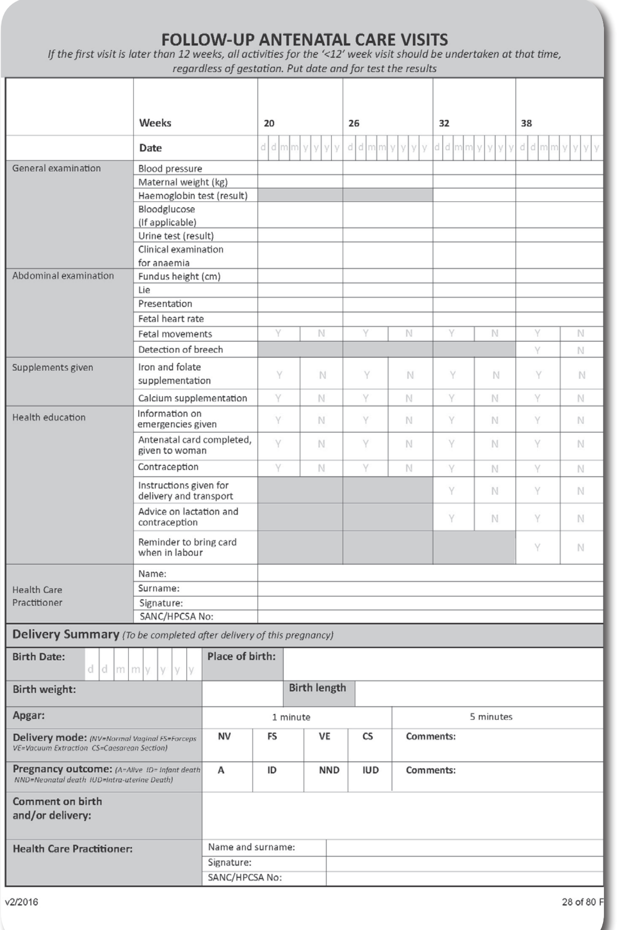

FOLLOW-UP ANTENATAL CARE VISITS

If the first visit is later than 12 weeks, all activities for the '<12' week visit should be undertaken at that time, regardless of gestation. Put date and for test the results

	Weeks	20		26		32		38	
	Date	ddmmyyyy		ddmmyyyy		ddmmyyyy		ddmmyyyy	
General examination	Blood pressure								
	Maternal weight (kg)								
	Haemoglobin test (result)								
	Bloodglucose (If applicable)								
	Urine test (result)								
	Clinical examination for anaemia								
Abdominal examination	Fundus height (cm)								
	Lie								
	Presentation								
	Fetal heart rate								
	Fetal movements	Y	N	Y	N	Y	N	Y	N
	Detection of breech							Y	N
Supplements given	Iron and folate supplementation	Y	N	Y	N	Y	N	Y	N
	Calcium supplementation	Y	N	Y	N	Y	N	Y	N
Health education	Information on emergencies given	Y	N	Y	N	Y	N	Y	N
	Antenatal card completed, given to woman	Y	N	Y	N	Y	N	Y	N
	Contraception	Y	N	Y	N	Y	N	Y	N
	Instructions given for delivery and transport					Y	N	Y	N
	Advice on lactation and contraception					Y	N	Y	N
	Reminder to bring card when in labour							Y	N
Health Care Practitioner	Name:								
	Surname:								
	Signature:								
	SANC/HPCSA No:								

Delivery Summary *(To be completed after delivery of this pregnancy)*

Birth Date: ddmmyyyy	**Place of birth:**				
Birth weight:	**Birth length**				
Apgar:	1 minute			5 minutes	
Delivery mode: *(NV=Normal Vaginal FS=Forceps VE=Vacuum Extraction CS=Caesarean Section)*	NV	FS	VE	CS	Comments:
Pregnancy outcome: *(A=Alive ID= Infant death NND=Neonatal death IUD=Intra-uterine Death)*	A	ID	NND	IUD	Comments:
Comment on birth and/or delivery:					
Health Care Practitioner:	Name and surname:				
	Signature:				
	SANC/HPCSA No:				

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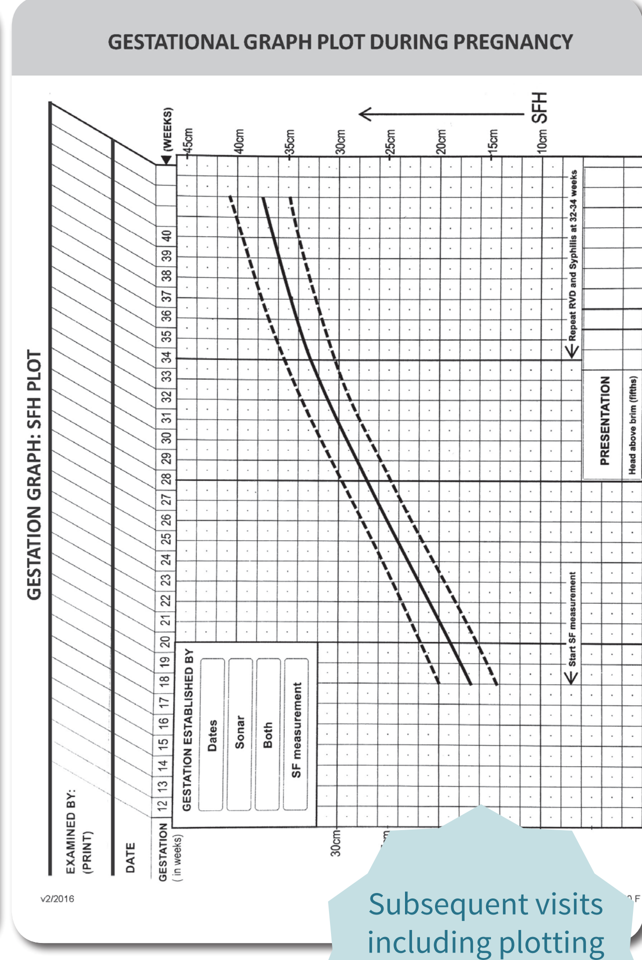
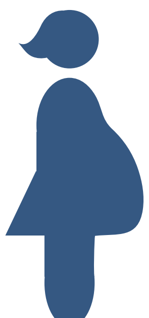


Subsequent visits including plotting of the gestational chart is included.



POSTNATAL CARE VISITS:

Complete this form the first time a pregnant woman presents for antenatal care for the pregnancy

		3 – 6 Days	6 week after delivery
General examination	Date:	ddmmyyyy	ddmmyyyy
	BP and		
	Temperature		
	Pulse		
	Urine test		
	Fundal height		
	Urinary problems / micturition		
	Vaginal bleeding : amount, colour and odour		
	Perineum		
	Haemorrhoids		
	Signs of thrombosis		
	Breasts problems		
	Signs of infections		
	HB		
Health education	Counseling and voluntary HIV testing		
	Provide information on diet, signs of		
	complications, nutrition		
	Contraception method		
	Emotional status		
	Ensure that Vit A and TT3 are given		
	Feeding method of choice		
Health Care Practitioner:	Name and surname:		
	Signature:		
	SANC/HPCSA No:		

Post natal care provided is recorded in this section.

3.3. CLINICAL RECORD FOR A CHILD (BIRTH – 15 YEARS)

The following thumbnails are examples of clinical records and are not intended to be complete.

CHILDREN CLINICAL RECORD

TABLE OF CONTENTS

Demographic details .... pg 2
Subsequent changes to demographics details ....pg 3-4
Patient profile – first visit ....pg 5-6
Annual review ....pg 7-9
Immunisations.. pg 10
Development screening.. pg 11
Growth chart – girl ....pg 1214
Growth chart – boy .... pg 15-17
Well child visit .... pg 18-19
ART initiation .... pg 20-21
Clinical management birth to 5 years .... pg 22-31
Clinical management 6 to 15 years .... pg 32-39
Oral healthcare .... pg 40-44
Rehabilitation .... pg 45-47
Laboratory test results .... pg 48-49
Prescription .... pg 50-57
TB adherence .... pg 58-61
Consent for HIVand other testing .... pg 62-64

Table of contents indicating composition of children's records.

HPRS Label | **DEMOGRAPHIC DETAILS** | Allergy sticker

Patient file number:	_ _ _ – _ _ _ – _ _ _
ID/passport number:	
Name:	
Surname:	
Date of birth:	d d m m y y y y
Facility name:	
Facility unique number:	
Gender:	Male / Female
RESIDENTIAL ADDRESS	
House number and street name:	
Suburb:	
Town/city:	
Postal code:	
MOTHER'S DETAILS	
Name of mother:	
Home telephone number:	
Cell number:	
FATHER'S DETAILS	
Name of father:	
Home telephone number:	
Cell number:	
GUARDIAN'S DETAILS	
Name of guardian:	
Home telephone number:	
Cell number:	
ALTERNATIVE CONTACT DETAILS	
Next of kin (name & surname)	
Relationship to patient:	
Home telephone number:	
Cell number:	
Date completed:	d d m m y y y y

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Health Repository label to be attached

All details to be completed by administrative clerk on registering patient for the first time.

A complete history is completed on the first visit.

PATIENT PROFILE - FIRST VISIT

Date of visit	d	d	m	m	y	y	y	y

Social *(please tick)*

Child lives with	Mother	Father	Both parents	Grandparent	Relative	Family friend	Foster parents	Home/place of safety

Living conditions:	Informal dwelling	Formal house	Hostel	Other (specify):		
	Number in household:					
	Piped water inside dwelling	Piped water outside dwelling	Communal tap	Borehole	Rain water	Stream water
	Flushing toilet in house	Flushing toilet outside	Pit toilet	VIP toilet	Bucket system	None
School grade *(where applicable)*	Attending school	Y	N	In grade expected for child of this age	Y	N
Social assistance	Disability grant	Child support grant	Foster care grant	Other (specify):		
Nutrition	Have you missed a meal due to unavailability of food in the last 2 days	Y	N			

Birth history: 0 – 1 year

Place of birth				
Birth weight				
Measurements at birth	Length:		Head circumference:	
Type of birth	Normal Vaginal	Caesarean	Breech	Assisted delivery
Apgar:	1 minute		5 minutes	

HIV exposed at birth:	Y	N	ART given	Y	N	Type of ART:	NVP	NVP+ AZT	Other (specify):	Date given: d d m m y y y y
(If yes); PCR done	d d m m y y y y		Results:	POS	NEG	On Cotrimoxazole	Y	N		
Problems during pregnancy, at birth and in first 6 weeks:										

Known Chronic Health Conditions *(tick if relevant)*

	Year diagnosed	Treatment
Congenital conditions	d d m m y y y y	
Developmental delay	d d m m y y y y	
Rheumatic heart disease	d d m m y y y y	
Asthma/Atopy	d d m m y y y y	
Epilepsy	d d m m y y y y	
HIV	d d m m y y y y	
TB	d d m m y y y y	
Other, specify:	d d m	

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PATIENT PROFILE - FIRST VISIT

To be completed at first visit

Past Surgical History

Previous operations	Date	Complications

Allergies:	Y	N	Specify:

Risk Factors: 10 – 15 years *(where applicable)*

Lifestyle

Alcohol:	Y	N	(If Yes)	Type:	Quantity:	Frequency:
Smoking/Tobacco:	Y	N	(If Yes)	Year Started:	Frequency:	
Other substances:	Y	N				

Sexual Health History *(where applicable)*	Are you sexually active?	Y	N	
	Have you had more than one partner in the last month?	Y	N	
	Do you use condoms every time you have sex?	Y	N	
	HCT done?	Y	N	Date of last test d d m m y y y y
				Results: Positive / Negative

Reproductive Health *(where applicable)*

Current contraceptive method:	Y	N	If yes; start date y y y y	Method:
			...yes; year done y y y y	If no, comment:

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PATIENT PROFILE - ANNUAL REVIEW

Social *(please tick)*

Child lives with	Mother	Father	Both parents	Grandparent	Relative	Family friend	Foster parents	Home/place of safety

Living conditions:	Informal dwelling	Formal house	Hostel	Other (specify):		
	Number in household:					
	Piped water inside dwelling	Piped water outside dwelling	Communal tap	Borehole	Rain water	Stream water
	Flushing toilet in house	Flushing toilet outside	Pit toilet	VIP toilet	Bucket system	None
School grade *(where applicable)*	Attending school	Y	N	In grade expected for child of this age	Y	N
Social assistance	Disability grant	Child support grant	Foster care grant	Other (specify):		
Nutrition	Have you missed a meal due to unavailability of food in the last 2 days	Y	N			
Date completed:	d d m m y y y y					

Social *(please tick)*

Child lives with	Mother	Father	Both parents	Grandparent	Relative	Family friend	Foster parents	Home/place of safety

Living conditions:	Informal dwelling	Formal house	Hostel	Other (specify):		
	Number in household:					
	Piped water inside dwelling	Piped water outside dwelling	Communal tap	Borehole	Rain water	Stream water
	Flushing toilet in house	Flushing toilet outside	Pit toilet	VIP toilet	Bucket system	None
School grade *(where applicable)*	Attending school	Y	N	In grade expected for child of this age	Y	N
Social assistance	Disability grant	Child support grant	Foster care grant	Other (specify):		
Nutrition	Have you missed a meal due to unavailability of food in the last 2 days	Y	N			
Date completed:	d d m m y y y y					

Changes in patients social history is updated annually.

Social *(please tick)*

Child lives with	Mother	Father	Both parents	Grandparent	Relative	Family friend	Foster parents	Home/place of safety

Living conditions:	Informal dwelling	Formal house	Hostel	Other (specify):		
	Number in household:					
	Piped water inside dwelling	Piped water outside dwelling	Communal tap	Borehole	Rain water	Stream water
	Flushing toilet in house	Flushing toilet outside	Pit toilet	VIP toilet	Bucket system	None
School grade *(where applicable)*	Attending school	Y	N	In grade expected for child of this age	Y	N
Social assistance	Disability grant	Child support grant	Foster care grant	Other (specify):		
Nutrition	Have you missed a meal due to unavailability of food in the last 2 days	Y	N			
Date completed:	d d m m y y y y					

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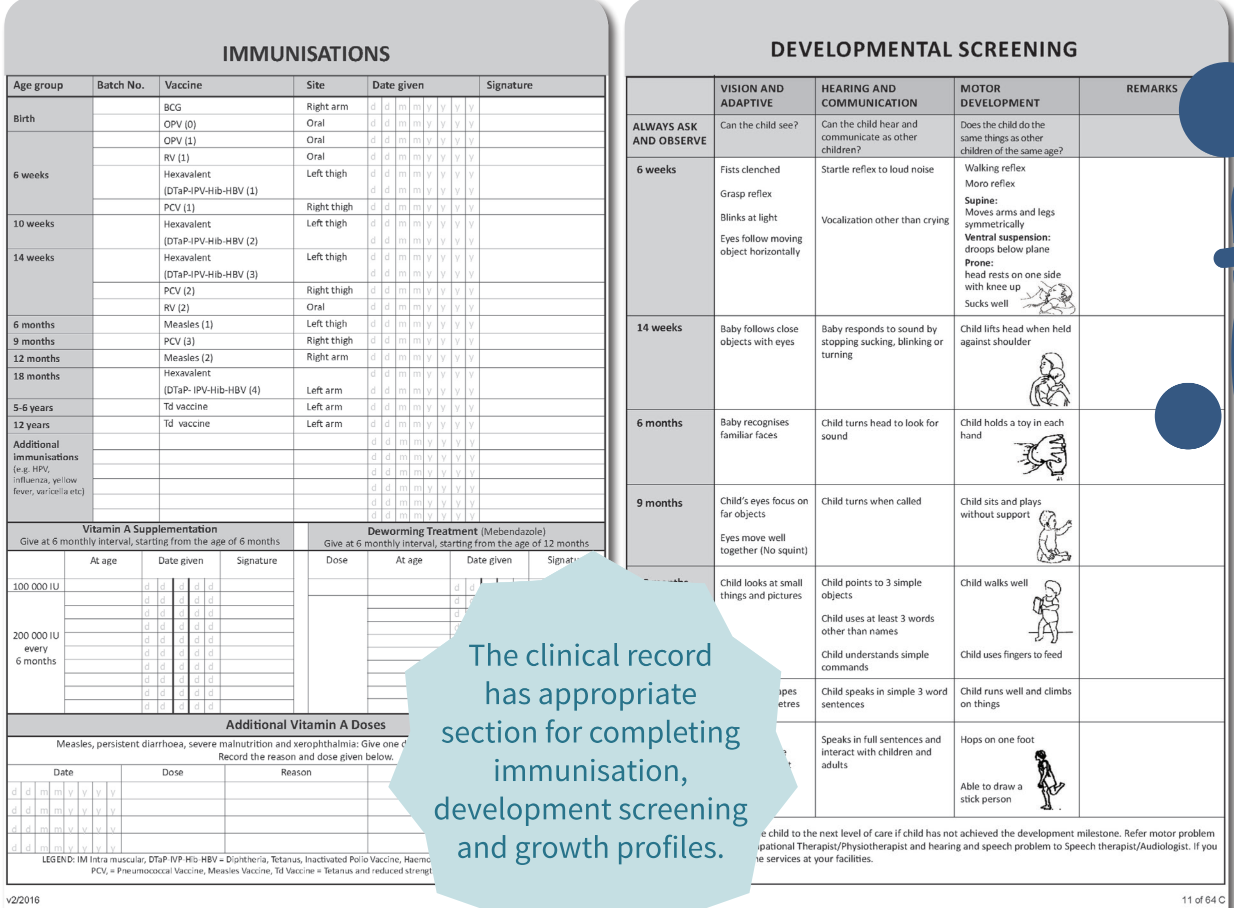

IMMUNISATIONS

Age group	Batch No.	Vaccine	Site	Date given	Signature
Birth		BCG	Right arm	d d m m y y y y	
		OPV (0)	Oral	d d m m y y y y	
6 weeks		OPV (1)	Oral	d d m m y y y y	
		RV (1)	Oral	d d m m y y y y	
		Hexavalent (DTaP-IPV-Hib-HBV (1))	Left thigh	d d m m y y y y	
		PCV (1)	Right thigh	d d m m y y y y	
10 weeks		Hexavalent (DTaP-IPV-Hib-HBV (2))	Left thigh	d d m m y y y y	
14 weeks		Hexavalent (DTaP-IPV-Hib-HBV (3))	Left thigh	d d m m y y y y	
		PCV (2)	Right thigh	d d m m y y y y	
		RV (2)	Oral	d d m m y y y y	
6 months		Measles (1)	Left thigh	d d m m y y y y	
9 months		PCV (3)	Right thigh	d d m m y y y y	
12 months		Measles (2)	Right arm	d d m m y y y y	
18 months		Hexavalent (DTaP- IPV-Hib-HBV (4))	Left arm	d d m m y y y y	
5-6 years		Td vaccine	Left arm	d d m m y y y y	
12 years		Td vaccine	Left arm	d d m m y y y y	
Additional immunisations (e.g. HPV, influenza, yellow fever, varicella etc)				d d m m y y y y	

Vitamin A Supplementation
Give at 6 monthly interval, starting from the age of 6 months

	At age	Date given	Signature
100 000 IU		d d m m y y y y	
200 000 IU every 6 months		d d m m y y y y	

Deworming Treatment (Mebendazole)
Give at 6 monthly interval, starting from the age of 12 months

Dose	At age	Date given	Signat...

Additional Vitamin A Doses
Measles, persistent diarrhoea, severe malnutrition and xerophthalmia: Give one d...
Record the reason and dose given below.

Date	Dose	Reason
d d m m y y y y		

LEGEND: IM Intra muscular, DTaP-IVP-Hib-HBV = Diphtheria, Tetanus, Inactivated Polio Vaccine, Haemo... PCV, = Pneumococcal Vaccine, Measles Vaccine, Td Vaccine = Tetanus and reduced strengt...

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DEVELOPMENTAL SCREENING

	VISION AND ADAPTIVE	HEARING AND COMMUNICATION	MOTOR DEVELOPMENT	REMARKS
ALWAYS ASK AND OBSERVE	Can the child see?	Can the child hear and communicate as other children?	Does the child do the same things as other children of the same age?	
6 weeks	Fists clenched Grasp reflex Blinks at light Eyes follow moving object horizontally	Startle reflex to loud noise Vocalization other than crying	Walking reflex Moro reflex **Supine:** Moves arms and legs symmetrically **Ventral suspension:** droops below plane **Prone:** head rests on one side with knee up Sucks well	
14 weeks	Baby follows close objects with eyes	Baby responds to sound by stopping sucking, blinking or turning	Child lifts head when held against shoulder	
6 months	Baby recognises familiar faces	Child turns head to look for sound	Child holds a toy in each hand	
9 months	Child's eyes focus on far objects Eyes move well together (No squint)	Child turns when called	Child sits and plays without support	
...	Child looks at small things and pictures	Child points to 3 simple objects Child uses at least 3 words other than names Child understands simple commands	Child walks well Child uses fingers to feed	
	...pes ...etres	Child speaks in simple 3 word sentences	Child runs well and climbs on things	
		Speaks in full sentences and interact with children and adults	Hops on one foot Able to draw a stick person	

...e child to the next level of care if child has not achieved the development milestone. Refer motor problem ...pational Therapist/Physiotherapist and hearing and speech problem to Speech therapist/Audiologist. If you ...e services at your facilities.

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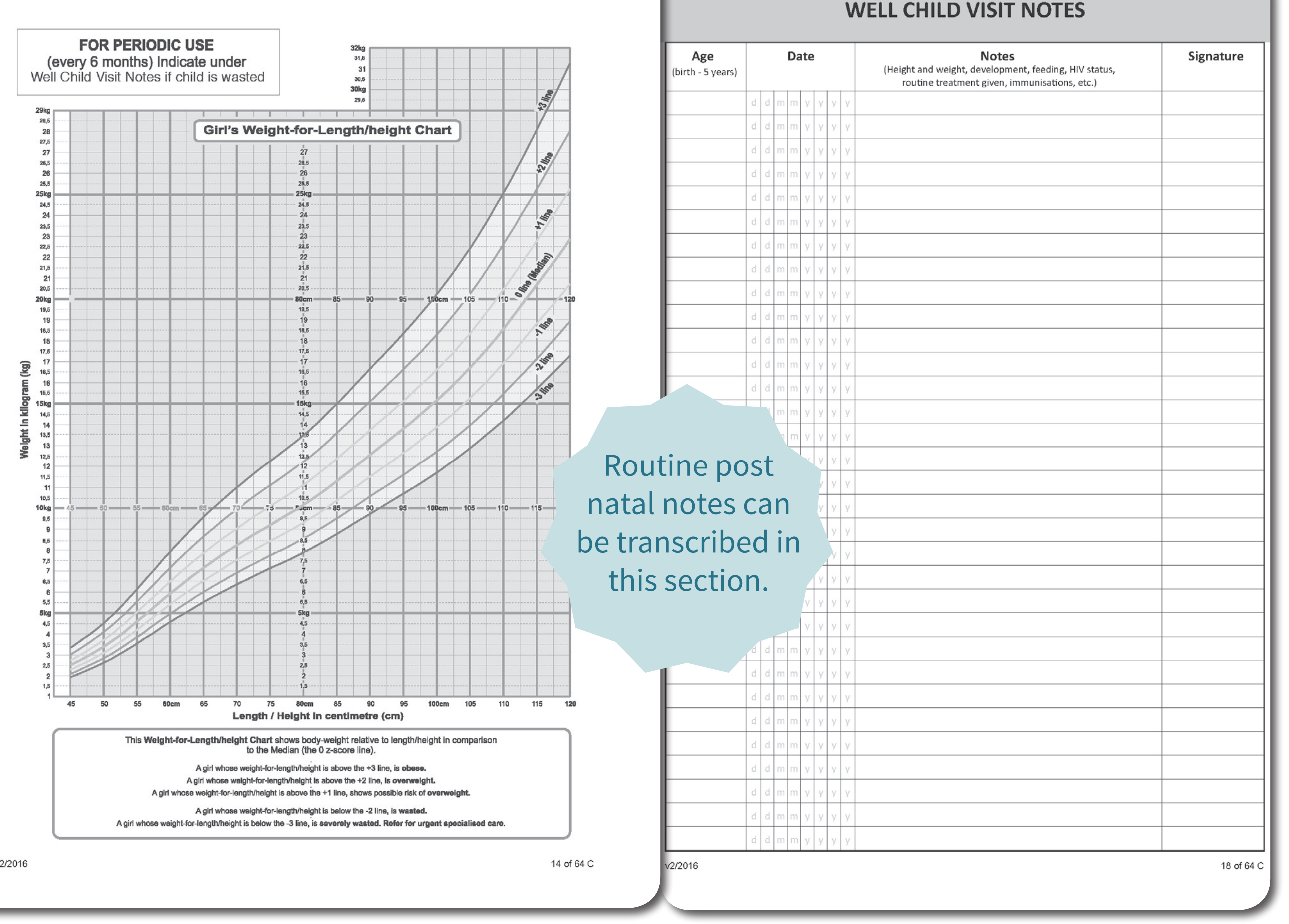
The clinical record has appropriate section for completing immunisation, development screening and growth profiles.



This Weight-for-Length/height Chart shows body-weight relative to length/height in comparison to the Median (the 0 z-score line).

A girl whose weight-for-length/height is above the +3 line, is obese.
A girl whose weight-for-length/height is above the +2 line, is overweight.
A girl whose weight-for-length/height is above the +1 line, shows possible risk of overweight.

A girl whose weight-for-length/height is below the -2 line, is wasted.
A girl whose weight-for-length/height is below the -3 line, is severely wasted. Refer for urgent specialised care.

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WELL CHILD VISIT NOTES

Age (birth - 5 years)	Date	Notes (Height and weight, development, feeding, HIV status, routine treatment given, immunisations, etc.)	Signature
	d d m m y y y y		

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Routine post natal notes can be transcribed in this section.

PRESCRIPTION

PATIENT'S NAME AND SURNAME		
ID:		AGE:
ALLERGIES:		

Date	DETAILS OF PRESCRIPTION Print the name of the drugs in the blocks below - NOTE ONE ITEM PER BLOCK		1 of 6 (Initial)	REPEATS 2 of 6	3 of 6	4 of 6	5 of 6	6 of 6
		Date						
		Quantity						
	or equivalent	Batch No						
		Dispenser Signature						
	Prescriber name, signature & qualifications	Print Name						
		Date						
		Quantity						
	or equivalent	Batch No						
		Dispenser Signature						
	Prescriber name, signature & qualifications	Print Name						
		Date						
		Quantity						
	or equivalent	Batch No						
		Dispenser Signature						
	Prescriber name, signature & qualifications	Print Name						
		Date						
		Quantity						
	or equivalent	Batch No						
		Dispenser Signature						
	Prescriber name, signature & qualifications	Print Name						
		Date						
		Quantity						
	or equivalent	Batch No						
		Dispenser Signature						
	Prescriber name, signature & qualifications	Print Name						
		Date						
		Quantity						
	or equivalent	Batch No						
		Dispenser Signature						
	Prescriber name, signature & qualifications	Print Name						

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A complete prescription is required in order to be compliant with Pharmacy Council requirements.

LABORATORY RESULTS

Done	Results							
	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
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	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:

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Allows for tracking of laboratory tests – when they were done and recording of results.

TB ADHERENCE

If patient was not diagnosed on sputum, indicate other method of diagnosis:

CSF | X-Ray | Aspiration/Biopsy | Mantoux: ....mm

Patient Category:

N New patient
RC Relapse (retreatment after cure)
RF Re-treatment after failure
RD Retreatment after default
OR All other Re-treatment cases not included in above categories

Classification of Disease:

ICD10 Code (According to list in back of TB register)

Pulmonary TB | Both | Extra PTB | Site Extra PTB

Multidisciplinary team:

Placed out: Y N

If no, reason:

Self-Supervised | **Parent/guardian supervised** | **Clinic**

Name of Community Health Worker:

Date: d d m m y y y y

Treatment

Intensive Phase (IP)

Drug:	RHZE	RH 60/60	Pyrazinamide (Z)	Etha
Dosage:				

Body weight at start of IP:

Month	Date

✓ = patient took medication
✗ = patient did not take medication
— = medication collected for self administration or supervision elsewhere

Health Care Practitioner

Name:
Surname:
Signature:
SANC/HPCSA No:

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TB ADHERENCE

Continuous phase (CP)

Drug:	RH	60/60	Z	E	Other
Dosage:					

Body weight at start of CP:

Month	Date	No of Doses taken

✓ = patient took medication
✗ = patient did not take medication
= medication collected for self administration or supervision elsewhere

...UPERVISOR

Tel/Cellphone:

	Age	Screened	IPT started	TB treatment started
		Y N	Y N	Y N
		Y N	Y N	Y N
		Y N	Y N	Y N
		Y N	Y N	Y N
		Y N	Y N	Y N

d d m m y y y y

Cured	Treatment completed	Treatment defaulted	Treatment failure	Died

...mear -ve at or 1 month prior to completion of treatment & on at least one previous occasion
...atient has completed treatment but does not have bacteriological proof of cure
... – Patient whose treatment is interrupted for 2 consecutive months or more
...ment – Patient who remained smear+ at 5 months during treatment
...atient who died for any reason during TB treatment

...errals

Moved (Patient moved to another facility in the same sub-district)
Transferred Out (Patient transferred to another sub-district. District, province)

Facility: Sub-district/District:
Province: Country:

Health Care Practitioner

Name:
Surname:
Signature:
SANC/HPCSA No:

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Records for patients on TB treatment are incorporated within the records.

ART INITIATION

To be completed at ART initiation or transfer-in

Transfer-in: Y N **Referral clinic:** **ART start date:** d d m m y y y y

Presents from:	TB Clinic	PMTCT	VCT	Other ART clinic	PHC	Inpatient	Other

Has patient/parent/guardian disclose HIV status Y N

CLINICAL ASSESSMENT: FIRST VISIT AT THIS CLINIC

WHO CLINICAL STAGING:

All children less than 5 years should be started on ART
Fast-tracking:
- Children less than 1 year of age
- CD4 count < 200 cells/ul or 15%
- WHO clinical stage 4
- MDR or XDR-TB

5 – 10 years: Symptomatic (stage 3 or 4) irrespective of CD4 count or CD4 ≤500 cells/ul irrespective of WHO stage

Adolescents 10 – 14 years: WHO stage 3 or 4, CD4 count ≤500 cells/ul

WHO stage	Clinical features		
WHO stage 1	Asymptomatic	Y	N
	Persistent generalised lymphadenopathy	Y	N
WHO stage 2	Unexplained persistent weight loss	Y	N
	Hepato splenomegaly	Y	N
	Papular pruritic eruptions	Y	N
	Extensive wart virus infection	Y	N
	Extensive molluscum contagiosum	Y	N
	Fungal nail infections	Y	N
	Recurrent oral ulcerations	Y	N
	Unexplained persistent Parotid enlargement	Y	N
	Lineal gingival erythema	Y	N
	Herpes zoster	Y	N
	Recurrent or chronic upper Respiratory tract infections (otitis media, otothoea, sinusitis or tonsillitis)	Y	N
WHO stage 3	Unexplained moderate malnutrition not adequately responding to standard therapy	Y	N
	Unexplained persistent diarrhoea (14 days or more)	Y	N
	Unexplained persistent fever (above 37.5oC intermittent or constant for longer than 1 month)	Y	N
	Persistent oral candidiasis (after first 6-8 weeks of life)	Y	N
	Oral hairy leukoplakia	Y	N
	Acute necrotizing ulcerative gingivitis or periodontitis	Y	N
	Lymph node tuberculosis	Y	N
	Severe recurrent bacterial pneumonia	Y	N
	Symptomatic lymphoid interstitial pneumonitis	Y	N
	Chronic HIV-associated lung disease including bronchiectasis	Y	N
	Unexplained anaemia (<8g/dl), neutropenia (<0.5 x 109 per litre)	Y	N
	And/or chronic thrombocytopenia (<0.5 x 109 per litre)	Y	N

WHO stage	Clinical features		
WHO stage 4	Unexplained severe wasting, stunting or severe malnutrition not responding to stand... therapy	Y	N
	Pneumocystis pneumonia	Y	N
	Recurrent s... pyomyositi... excluding...		
	Chronic... of mor...		
	D... mycoo...		
	Chronic cryptosp...		N
	Chronic isosporiasis	Y	N
	Disseminated non-tuberculous mycobacterial infection	Y	N
	Cerebral or B-cell non-Hodgkin lymphoma	Y	N
	Progressive multifocal leuko-encephalopathy	Y	N
	Symptomatic HIV-associated nephropathy or HIV-associated cardiomyopathy	Y	N
	HIV-associated recto-vaginal fistula	Y	N

NUTRITIONAL ASSESSMENT

Baseline weight for age, height for age, weight for height and head circumference-for-age z-scores and/or BMI.

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ART INITIATION

To be completed at ART initiation or transfer-in

HISTORY AND EXAMINATION & PLAN

Expose to TB: Y N	Screened for TB: Y N	On TB treatment Started date: d d m m y y y y	Y N
Screened for Cotrimoxazole: Y N	Already on Cotrimoxazole: Y N	Qualifies/started Cotrimoxazole: Date: d d m m y y y y	Y N
CD4 ≤500 cells/ul Y N	WHO stage 3 or 4 Y N		

PSYCHO-SOCIAL READINESS

Has patient/parent/guardian attended all required counselling sessions? Y N
Does patient/parent/guardian attend support group sessions Y N
Does patient attended the clinic regularly? Y N

PRE-ART COUNSELLING

Session	Date	Counsellor/group	Treatment buddy attended?	Comments
General HIV Education and Healthy Living			Y N	
...tiretroviral Therapy			Y N	
...e Planning			Y N	
			Y N	

...d details for treatment buddy

...arent/guardian ...home visit? Y N | Name of community health worker: | Attends a support group: Y N

...ent/parent/guardian understanding (in their own words) for wanting ART

...SELINE SAFETY BLOODS

...est	Date	Result	Notes
ALT			
Haemoglobin			
CD4			
Creatinine Clearence			
Cholesterol			
Triglycerides			
Other:			

TREATMENT PLAN

Plan:	ARV 1	ARV 2	ARV 3
Next visit in:	weeks		

Health Care Practitioner

Name:
Surname:
Signature:
SANC/HPCSA No:
Date completed: d d m m y y y y

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Anti-retroviral treatment initiation does not require additional stationery.

3.4. CLINICAL SUPPORT BY MEDICAL DOCTORS AND DCST

In situations where the facility does not have a medical practitioner, the DCST should perform the following role:

- Supervision, training and mentoring of professional nurses, PHC nurses in management of chronic diseases.
- Conducting clinical audits.
- Primary referral for complicated cases.
- Strengthening the referral mechanism to district and regional hospitals.
- Monitoring patient clinical outcomes.

The aim of clinical mentorship is to equip healthcare providers with the clinical knowledge, skills and attitudes to achieve competence and confidence in the provision of quality care. It helps to have someone to whom one can go and ask questions, and get help with diagnosing, managing or prescribing.

SECTION SIX
STRENGTHENING INDIVIDUAL AND POPULATION HEALTH

'ASSISTED' SELF- MANAGEMENT → COLLABORATION WITH WARD BASED OUTREACH TEAM → HOUSEHOLD VISITS → ADHERENCE CLUBS AND SUPPORT GROUPS

POPULATION HEALTH AWARENESS & SCREENING → HEALTH AWARENESS DAYS → UNIVERSAL TEST AND TREAT → INTEGRATED SCHOOL HEALTH TEAM → WARD BASED OUTREACH TEAMS

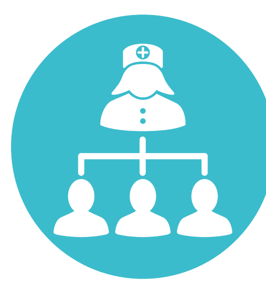
This section of the manual provides a definition of ***Assisted Self-management***, defines the role of the CHW's and links with population awareness.

'ASSISTED' SELF-MANAGEMENT

- Health promotion and education at community level
- Identification of at-risk patients within the household
- Point of care testing and screening
- Support groups and adherence clubs
- Medication delivery (courier service)

POPULATION HEALTH AWARENESS & SCREENING

- Health awareness campaigns
- Universal test and treat
- Social marketing.
- Screening services
- Integrated School Health Teams



1. 'ASSISTED' SELF-MANAGEMENT

Assisted Self-management aims at supporting patients to take responsibility for their own health. ICSM will be implemented through ward based outreach teams providing health promotion, point of care testing and medication adherence support and act as couriers in certain circumstances.

1.1. ROLE OF THE CHW IN ASSISTED SELF-MANAGEMENT

1. The CHW is part of the PHC ward based outreach team.
2. The CHW will serve as a link between the facility and the community.
3. The CHW will provide ***health education and promotion*** to reducing the risk factors of chronic diseases as well as preventing complications. This will include, but not be limited to:
    a. Healthy eating habits
    b. Active living through appropriate exercising
    c. Reduction in tobacco and snuff use
    d. Decrease in alcohol intake
    e. Reduction in salt intake
4. The CHW will offer ***point of care screening*** for at risk clients during the home visits. This will include:
    a. Household assessments –Social Services
    b. Blood pressure measurements
    c. Waist circumference measurement
    d. Body mass index calculations
    e. Blood sugar screening
    f. Symptoms screening for TB
    g. Voluntary counselling for HIV

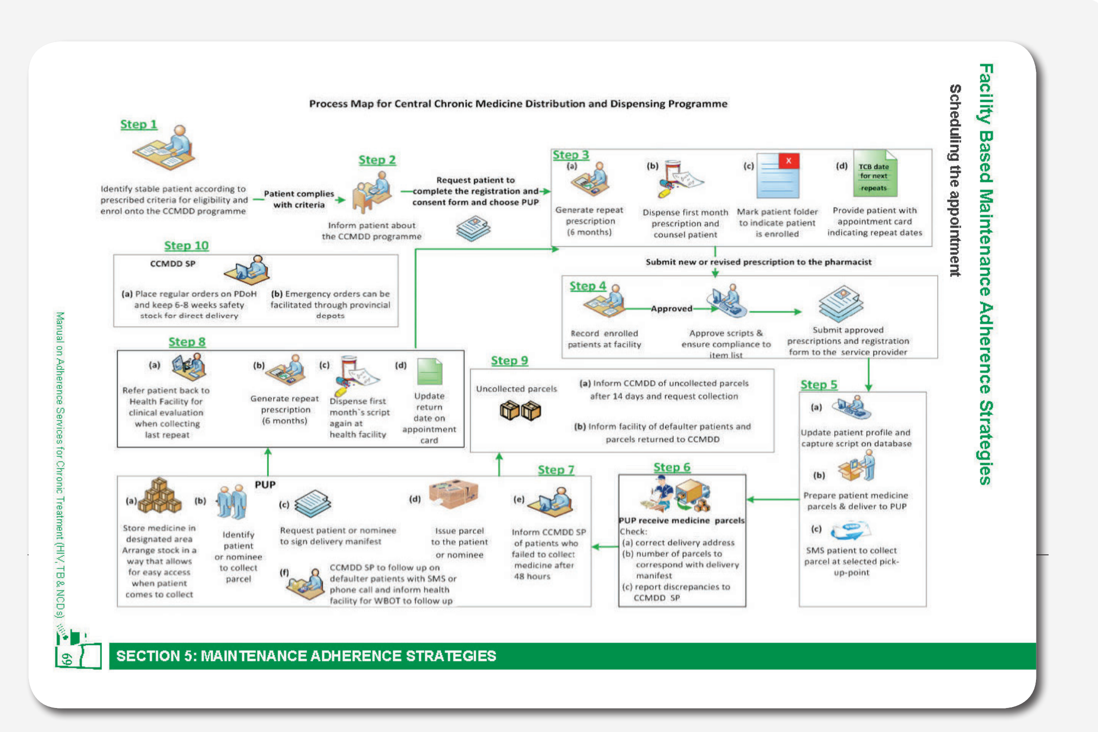
1.2. CENTRAL CHRONIC MEDICINE DISTRIBUTION AND DISPENSING

The CCMDD programme has been implemented to improve patient access to required medicines for chronic conditions, as well as to assist in decongesting public clinics. This means that facilities are not inundated with chronic stable conditions. The programme has two components i.e.the actual central dispensing where this occurs off-site at a central location by a service provider and Pick-Up Points (PuPs)which may include the facility or be in communities.

The diagram below highlights the process from identification of patients to the distribution and collection of medication and includes.

- Registration
- Patient enrollment and consent
- Dispense 1st issue of repeat
- Prescription authorization
- Dispensing
- Prescription capture
- Dispense subsequent months
- Distribution
- Distribute to Pick-up Point
- Send SMS to patient
- Collection
- Receipt and management of parcels
- Identify patient and issue
- Notify facility if uncollected
- Return uncollected parcels
- Tracing
- Defaulter tracing
- Provide feedback to facility

PROCESS MAP FOR CCMDD PROGRAMME



SOURCE: ADHERENCE SERVICES FOR CHRONIC TREATMENT (HIV,TB & DCDS) MANUAL

1.3. ADHERENCE CLUBS

The following information pertains to adherence clubs and is copied from the 'Manual for Adherence Services for Chronic Treatment'. Adherence clubs are used as an additional strategy to enhance the self management of patients. These clubs provide support and a safe haven for patients to discuss concerns around their chronic conditions with non-health professionals. They include patients who are adherent and stable on treatment, and may be facility or community based.

ADHERENCE CLUB MODEL

SECTION 5: MAINTENANCE ADHERENCE STRATEGIES

Adherence Model

Note that adherence model is not a one size fits all strategy. The adherence model should focus on one main condition (e.g. HIV or hypertentison, Tuberculosis and Diabetes) but club facilitators should provide treatment for different treatments in case some clients are co-infected with other chronic conditions. The manual will explore both facility and community based chronic adherence clubs.

Facility and community based Chronic Adherence Clubs.

- **Membership:** An adherence Club consists of a group of no more than 30 clients who are judged to be adherent to and stable on treatment
- **Timing:** Club members meet every 3 month as a group.
- The Club visit lasts approximately 1-1/2 hours.
- Each Club should consider an appropriate time for the adherence club considering accessibility for working clients (early morning or after work).
- At facilities, off peak, low client load periods could be considered with less pressure on space and human resources.

The Process

- **Process:** At each club visit, club members are clinically assessed (by weight and symptom screening), participate in a group support/education activity issue with 3 months pre-dispensed medication in the club venue.
- Annually, monitoring blood tests are taken in the Club (E.g. for HIV: CD4, viral load).
- At the following visit, all club members have an individual clinician consultation.
- **Facility based Clubs:** Every 3 months, clients meet as a group at clinic facilities, where facility space is limited, community venues close to the facility that don't require additional logistical support can be utilised.
  - Facilities can also make use of extended hours by establishing evening Clubs.

The Adherence club

- Community based Clubs: Every 3 months, club sessions are hosted in one of the client's homes or community venues near their home (e.g. NGO, church).
- Their pre-packed treatment is brought to them by the club facilitator.
- They are still clients at the main referral clinic but are only required to attend the facility for annual blood taking and clinical consultation.

Team, role and responsibilities:

- Each clinic should have a designated Clubs Manager who takes overall responsibility for the activities required to run successful clubs.
- This manager should be a nurse.
- Their duties include: ensuring their clubs team is in place, the club SOP is being carried out, scheduling annual return dates for club visits, ensuring the 6 monthly scripts are being coordinated and completed by the team.
- The clubs manager needs to have a good overview of the club outcomes and is responsible for completing monthly club stats for submission to the facility manager.

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- Each club is assigned a **Club Facilitator** (a counsellor, peer educator, community health worker or equivalent) and a Club PN (Professional Nurse).
- Other possible team members could include a data capture/clerk and pharmacy assistant.
- The Club Facilitator (counsellor, peer educator, community health worker or equivalent) is responsible for preparing the clubs, running the club session, and their duties include:
  - Collecting pre-packed treatment dispensed from pharmacy, registering members, conducting the support group conducting symptom screening, referring clients to Club PN if necessary, issuing pre-packed treatments, completing club registers and following up clients who miss sessions.
- The Club PN is responsible for clinical oversight of a Club on the day of the club visit. His/her duties also include:
  - Seeing symptomatic clients referred by the Club Facilitator, drawing bloods for club clients on the annual blood visit and providing clinical consultation of club clients at their annual clinical review.
- Pharmacist or Pharmacy Assistant is responsible for pre-packing ART for clubs.
- Data Capturer is responsible for capturing the club client's visit from club register into the facility register after a grace period.
- Note: Only the Club Facilitator is always present at each club session. The Club PN is not present at the club session but available during and after the session to see symptomatic clients, take bloods and conduct annual consultation as necessary.

Club Organogram

- A club organogram is useful to clarify each team member's role in managing and supporting facility clubs.
- Clear roles and responsibilities for each team member improves staff participation in the model.
- The clubs manager requires authority (from facility manager) to ensure implementation and effective running of the clubs.
- Daily rotation of the club nurse function within the facility enables collective responsibility for the club clients' management.

Clinical Care and Counselling:

- Club members with symptoms/weight loss/other clinical problems are referred by Club facilitator and receive an individual consultation with the Club PN on the same day.
- Annually, monitoring blood tests are taken in the Club.
- At the following visit, all club members have an individual consultation with a clinician.
- Club members are re-scripted for ARV drug supply purposes every six months.

Club Records:

- Each Club has a club file that contains the scripts of the club members and a Club register which records attendance, weight, results of symptom screening and blood results.

Clients file are only drawn at re-scripting visits, at annual clinical consultation or if a Club member receives a consultation during a routine Club visit

DETAILED OUTLINE/FUNCTIONING OF CLUBS

Eligibility Criteria for Club membership

A client may qualify to join a clubs if (s) he meets the following criteria:

- Adult > 18 years
- On the same regimen for at least 6 months (regimen 1 or 2). However, in the case of a single drug substitution, clinician to determine when eligible.
- Stable on treatment (to be determined clinically according to the guidelines). E.g., for HIV, most recent viral load undetectable; the most recent of these taken in past 6 months (thus minimum of 6 months on treatment).
- OR client stable on second line Regimen
- Pregnant women and women on PMTCT follow-up up can join or remain in the club granted that they do the ANC/PMTCT follow-up separately.
- No current TB in the intensive phase
- No medical condition requiring regular clinical consultations

Doctors or nurses determine and confirm the clients' eligibility for Club membership.

- Membership of a Club is voluntary
- Allocating clients to a Club designated for a specific feeder area makes it easier to move clubs into the community later on (easiest to start with facility-based clubs).
- Club members may be excluded from the Club based on a number of clinical and adherence criteria but may return to club at discretion of clinician.

Club attendance requirements

a. Club members may send a buddy to collect medication for them on their Club visit day except:
    - on date of first attendance at the club
    - on a blood day
    - on a clinical consultation day

b. Where the Club member sends a buddy on the blood day or the clinical consultation day, the buddy will be asked to inform the Club member that they need to come to the clinic to see the Clubs Manager within 5 working days of the club visit date.

c. If a Club member sends a buddy to collect medication, 'buddy' is recorded in the register in the place of the weight. The buddy is informed that the Club member must attend the next visit.

d. Should the Club member present within 1 week (5 working days), the Clubs manager reviews the case and, where appropriate, refers to pharmacy for issuing the treatment. This will be recorded in the Club register as a visit. If a blood, clinical or scripting visit the Clubs Manager will ensure that appropriate action taken for the specific visit.

e. However, should a Club member not attend personally or send a buddy to collect meds within 1 week (5 working days) of the club day, the Club member will be regarded as a non-attendee of the Club.

He/she will be recorded as a DNA (Did Not Attend) in the Club register.

f. In the case of using an electronic register, the client must be recorded as DNA (not defaulter) as the client has not defaulted from the clinic.
g. Non-attendee members will be recalled through the contact details recorded in the register and the client will be required to return to mainstream care once they attend the clinic again.

Clinical management of Clubs

- At each visit, Club Facilitator is responsible for ensuring that:
  - The Club member is weighed, and weight recorded in register.
  - The Club member is asked – individually / in group / both – re the following, and results of the screening are entered into register:
  - TB symptoms (cough, weight loss, night sweats, fatigue)
  - Late onset treatment side effects
  - Pregnancy
  - Any other symptoms of concern
- Where the Club member is identified with any of the above symptoms, the Club member is referred to the Club PN for an individual consultation with their folder.
- The Club facilitator should also review the weights in the register to determine whether a client has lost weight. If this is the case, this client should be referred to the Club PN.
  - The Club PN consults these identified Club members.
  - The clinician(s) decide whether Club members referred from Club should remain in the Club or return to mainstream care

Pharmacy

- At enrolment visit Treatments will either be pre-packed by clinic pharmacy or each newly enrolled Club Member will attend the pharmacy after enrolment club visit for collection of medication.
- At facility a standard **facility script** is in use:
- The Clubs Manager must ensure that Club members are re-scripted 6 monthly at M6 by clinician at clinical consultation visit and at M12 and every 6 months thereafter.
- It should be clear on the club schedule when 6 monthly, re-scripting should be completed
- The Club file will be taken to the pharmacy at least 3 days prior to the club visit for pre-packing, and then be returned by the clinic pharmacy to the Clubs Manager.
- Pre-dispensed treatments to be issued at Club visit.
- It is recommended that the Club PN on duty for the club visit be responsible for its re-scripting.

Monitoring and Evaluation of adherence club

- Each club has a Club file, which contains a copy of the Club member's script (standard/CDU script). The file should also contain patient stickers.
- The Club File should be kept with the Club register (including the Club Tally sheet)
- Club register to be used every visit. The club tally sheet at the back of the register should also be completed at every visit.
- The Club register should be regularly reviewed by Clubs Manager.
- 5 days after the club visit, relevant information in the Club register must be transferred to the facility chronic register (paper or electronic) by the clinic data capture/clerk.
- Once monthly the Clubs Manager be responsible for providing the monthly club attendance data to the operational manager who will collate data together with other facility indicators and submit to the sub-structure co-ordinator
- At Facility level: club enrolment, club attendance, return to mainstream care (i.e. exited club),BP, weight, CD4 and Viral Load
- At Sub-district level: only enrolment, attendance at clubs and returns to mainstream care.

4.3.3 Fast/Spaced Appointments

Allowing a reduced frequency of clinical appointment and longer supply of drugs for healthy and stable patients on treatment can help reduce the burden on health workers and patients.

- In the spaced appointment system, clinically stable patients are requested to attend the clinic once a year for clinical assessment and drawing of blood (instead of every 1 or 2 months)
- Patients receive 6 months' prescription for their medication
- Each time they visit the health facility, stable patients should be allowed to collect at least 3 months' treatment
- Patients should be allowed to go through a fast lane system, meaning direct and quick access to the pharmacy
- In case of health problems or pregnancy, patients return to regular clinical care.

SOURCE: ADHERENCE SERVICES FOR CHRONIC TREATMENT (HIV,TB & DCDS) MANUAL

2. POPULATION HEATH AWARENESS & SCREENING

An informed and activated population is an essential criteria for decreasing the burden and long term complications associated with many illnesses, as well as decreasing the burden on the health system. The aim is to improve the well-being of the entire population, by addressing the range of factors that affect people's health within homes, schools, workplaces and communities. This will be achieved through a number of strategies.

- Primary prevention is most successful population level, to increase awareness of health and their direct impact on the development of diseases.
- The WBPHCOTs should play a significant role in increasing levels of awareness of chronic diseases This can be achieved through participation in awareness campaigns, which may include organised events within the health calendar.
- Social marketing should be used to raise awareness about chronic conditions.
- Screening services should be provided at strategic points to identify asymptomatic risk individuals and refer them appropriately.

2.1. HEALTH CAMPAIGNS AND OPEN DAYS AT HEALTH FACILITIES

MONTH	HEALTH AWARENESS DAYS (SELECTED)
January	Finding of clinical audit and discussions with staff, facility manager and PHC supervisor.
February	*Healthy lifestyles Awareness Month* **15** Healthy Lifestyles Awareness Day **10-16** Pregnancy/STI/Condom week
March	**24** World TB Day
April	**7** World Health Day
May	*Anti-tobacco Campaign Month* **12** International Nurses Day **17** World Hypertension **12** World no Tobacco Day
June	**17-23** June National Epilepsy Week **21** National Epilepsy Day
July	*Mental Illness Awareness Month*
August	*National Woman's Month* **9** National Woman's Day
September	*National Heart Awareness Month* *Cervical Cancer Awareness Month* **29** World Heart Day
October	**10** World Mental Health Day **28-3** Nov World Stroke Week **29** World Stroke Day
November	**14** World Diabetes Day
December	**1** World AIDS Day

2.2. UNIVERSAL TEST AND TREAT

Universal Test and Treat (UTT) is a strategy identifying HIV infected individuals through community based testing and opportunistic testing. All HIV infected individuals are the offered treatment.

Overall goal

In order to reduce the incidence of HIV infection in South Africa through the provision of expanded prevention and treatment options:

- all HIV positive children, adolescents and adults regardless of CD4 count will be offered ART treatment, prioritising those with CD4 ≤350.
- patients in the pre-ART and wellness programme shall be considered for UTT.
- willingness and readiness to start ART shall be assessed and patients who are not ready after assessment shall be kept in the wellness programme, and continuous counseling on the importance of early treatment and scheduled CD4 as per South African Clinical Guidelines shall continue at every visit.
- baseline monitoring of CD4 count must still be done for all patients that do not take up UTT as it is the key factor in determining the need to initiate.
- opportunistic Infection prophylaxis at CD4 ≤200, identify eligibility for CrAg at CD4 ≤100, prioritisation at CD4 ≤350 and fast tracking at CD4 ≤200.
- ART should be initiated as soon as the patient is ready and within two weeks of CD4 count being done.
- all HIV-positive pregnant or breastfeeding women, with no active TB or contra-indication to FDC (TDF/FTC/EFV) will be given immediat priorty.
- fast-track initiation applies to HIV stage four patients with CD4 ≤200 cells In case of TB. If diagnosed with TB, start TB treatment first, followed by ART as soon as possible and within eight weeks.
- if CD4 <50 cells initiate ART within 2-8 weeks after starting TB treatment. In cases with Cryptococcal or TB meningitis defer ART initiation for 4-6 weeks.

2.3. INTEGRATED SCHOOL HEALTH TEAM

ISHTs will provide preventive and promotive services for all leaners at school and refer the learners for further investigation and management should the need arise.

ISHTs are part of the PHC re-engineering framework. They act as a link between learners at school and the health system. ISHTs will primarily conduct health education and awareness campaigns at school level and provide screening services to assist with the early detection of chronic diseases and the appropriate referral of these high-risk patients.

The following is a list of services to be provided based on the grade of the child:

PACKAGE OF SCHOOL HEALTH SERVICES

Health Screening	On-site service	Health Education
Foundation phase (Gr R-3)		
• Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment (Gross & fine motor) • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial Support	• Parasite control: De-worming and bilharzia control (where appropri-ate) • Immunisation • Oral health (where avail-able) • Minor ailments	• Hand washing • Personal & environmental hygiene • Nutrition • Tuberculosis • Road safety • Poisoning • Know your body • Abuse (sexual, physical and emotional abuse)
Intermediate phase (Gr 4-6)		
• Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial Support	• Deworming • Minor ailments • Counselling regarding SRH (if indicated), and provision of and referral for services as needed	• Personal & environmental hygiene • Nutrition • Tuberculosis • Medical and Traditional Male circumci-sion • Abuse (sexual, physical and emotional abuse including bullying, violence) • Puberty (e.g. physical and emotional changes, menstruation & teenage pregnancy) • Drug & substance abuse
Senior phase (Gr 7-9)		
• Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment incl. anaemia • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial support	• Minor ailments • Individual counselling regarding SRH, and pro-vision of or referral for services as needed	• Personal & environmental hygiene • Nutrition • Tuberculosis • Abuse (sexual, physical and emotional abuse including bullying, violence) • Sexual & reproductive health • Menstruation • Contraception • STIs incl. HIV • MMC & Traditional • Teenage pregnancy, CTOP, PMTCT • HCT & stigma mitigation • Drug and substance abuse • Suicide

SOURCE: INTEGRATED SCHOOL HEALTH POLICY, 2012

PRE-IMPLEMENTATION
- BRIEFING OF STAFF
- SELECTION OF START DATE
- FACILITY ICSM TEAM
- COMMUNITY AWARENESS

DATA COLLECTION
- FACILITY WALK THROUGH
- FACILITY DATA COLLECTION
- WAITING TIME SURVEY
- HUMAN RESOURCE TRAINING AUDIT

DATA ANALYSIS
- NUMBER OF PATIENTS TO BE BOOKED DAILY
- NUMBER OF CONSULTATION ROOMS PER STREAM
- PROCESS FLOW
- HUMAN RESOURCE TRAINING REQUIREMENTS
- MANAGEMENT OF PATIENT RECORDS

ADMINISTRATIVE RE-ORGANISATION
- CREATING A SAFE ENVIRONMENT
- SIGNAGE (INTERNAL AND EXTERNAL)
- SINGLE ADMINISTRATIVE POINT
- MANAGEMENT OF APPOINTMENTS

SERVICE RE-ORGANISATION
- FOUR STREAMS OF CARE
- APPOINTMENTS
- FAST QUEUE
- CCMDD OR PRE-DISPENSING
- DOWN REFERRAL

CLINICAL MANAGEMENT SUPPORT
- CLINICAL GUIDELINES AND TOOLS
- CLINCIAL STATIONERY & PATIENTS RECORDS
- TRAINING OF STAFF
- DR & DISTRICT CLINICAL SPECIALIST TEAM

'ASSISTED' SELF- MANAGEMENT
- COLLABORATION WITH WARD BASED OUTREACH TEAM
- HOUSEHOLD VISITS
- ADHERENCE CLUBS AND SUPPORT GROUPS

POPULATION HEALTH AWARENESS & SCREENING
- HEALTH AWARENESS DAYS
- UNIVERSAL TEST AND TREAT
- INTEGRATED SCHOOL HEALTH TEAM
- WARD BASED OUTREACH TEAMS

MONITORING AND EVALUATION
- WAITING TIME SURVEY
- PATIENT EXPERIENCES SURVEY
- CLINICAL AUDIT
- PERFORMANCE INDICATORS
- ADHERENCE TO APPOINTMENTS SURVEY
- DASHBOARD

PRE-IMPLEMENTATION PREPAREDNESS

HEALTH SERVICE RE-ORGANISATION

STRENGTHENING INDIVIDUAL AND POPULATION HEALTH

SECTION SEVEN
MONITORING & EVALUATION

MONITORING AND EVALUATION → WAITING TIME SURVEY → PATIENT EXPERIENCES SURVEY → CLINICAL AUDIT → PERFORMANCE INDICATORS → ADHERENCE TO APPOINTMENTS SURVEY → DASHBOARD

This section of the manual provides an overview of monitoring and evaluation of ***Integrated Clinical Services Management***

1. MONITORING

Monitoring and evaluation (M&E) is an essential part of any programme, large or small. The practice of M&E can contribute to sound governance in a number of ways:

- improved evidence-based policy making (including budget decision making)
- development of policy
- improved management and accountability

Monitoring is the systematic collection and analysis of information as a project progresses and forms an integral part of day-to-day operational management to assess progress against objectives. It is aimed at improving the efficiency and effectiveness of a project or organization and is based on targets set and activities planned during the planning phases of work.

1.1 IDEAL CLINIC DASHBOARD (ICSM RELEVANT COMPONENTS)

The Ideal Clinic dashboard relevant to the implementation of ICSM should be audited on a monthly basis.

IDEAL CLINIC DASHBOARD

DOMAIN 2: PATIENT SAFETY AND CLINICAL GOVERNANCE AND CLINICAL CARE

2. Integrated Clinical Services Management (ICSM)

No.	Item					
	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					
22	The facility has been reorganised with designated consulting areas and staffing for acute, chronic health conditions and preventative health services.	E	☺	HF		
23	Patient are consulted, examined and counselled in privacy	I	☺	HF		
24	TB treatment success rate is at least 85% or has increased by at least 5% from the previous year	E	📖	HF		
25	TB (new pulmonary) defaulter rate < 5%	E	📖	HF		
26	Ante-natal visit rate before 20 weeks gestation is at least 67% or has increased by at least 5% from the previous year	E	📖	HF		
27	Ante-natal patient initiated on ART rate is at least 96% or has increased by at least 5% from the previous year	E	📖	HF		
28	Immunisation coverage under one year (annualised) is at least 87% or has increased by at least 5% from the previous year	E	📖	HF		
30	Quality Improvements plans are signed off by the facility manager and updated quarterly	I	📖	HF		
31	Six monthly district/sub-district clinical performance review report with action plan from clinical quality supervisors 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					
32	Patients have access to a medical practitioner	E	📖	HF		
33	Patients have access to oral health services	I	📖	D		
34	Patients have access to occupational therapy services	I	📖	D		
35	Patients have access to physiotherapy services	I	📖	D		
36	Patients have access to dietetic services	I	📖	D		
37	Patients have access to social work services	I	📖	D		
38	Patients have access to radiography services	I	📖	D		
39	Patients have access to ophthalmic service	I	📖	D		
40	Patients have access to mental health services	E	📖	D		
41	Patients have access to speech and hearing services	I	📖	D		
42	Staff dispensing medicine have access to the support of a pharmacist	I	📖	D		
43	Adolescent and youth friendly services are provided	I	📖	D	Y	
	7. Management of patient appointments: Monitor whether an ICSM patient appointment system is adhered to					
44	An ICSM compliant patient appointment system for patients with chronic health conditions and MCWH patient is in use	I	📖	HF		
45	The records of booked patients are pre retrieved not later than the day before the appointment	I	☺	HF		
46	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	E	? ☺	HF		

Domain	Sub-domain		No.	Standard					
		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							
			47	Facility does referrals to and receive referrals from school health services in its catchment area	I	🕮	D		
			48	The facility refers patients with chronic but stable health conditions to home- and community-based services for support	E	🕮	HF		
			49	Facility refers environmental health related risks to environmental health services	I	🕮	D	Y	
DOMAIN 2: PATIENT SAFETY AND CLINICAL GOVERNANCE AND CLINICAL CARE	2. Integrated Clinical Services Management (ICSM)	**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**							
			50	The ICSM compliant package of clinical guidelines is available in all consulting rooms	E	🕮	HF	**Y**	
			51	National guidelines on priority health conditions are available in the facility	I	🕮	HF	**Y**	
			52	80% of professional nurses have been fully trained on Adult Primary Care OR Practical Approach to Care Kit	E	🕮	D		
			53	80% of professional nurses have been fully trained on Integrated Management of Childhood illness	E	🕮	D		
			54	Resuscitation protocol is available	E	🕮	HF		
			55	80% of professional nurses have been trained on Basic Life Support	E	🕮	D		
			56	The National Guideline for Patient Safety Incident Reporting and Learning is available	E	🕮	NDoH		
			57	The patient safety incident records show compliance to the National Guideline for Patient Safety Incident Reporting and Learning	E	🕮	HF	**Y**	
			58	The National Clinical Audit guideline is available	E	🕮	NDoH		
			59	Clinical audits are conducted quarterly on priority health conditions	E	🕮	HF		
			60	Clinical audit meetings are conducted quarterly in line with the guidelines	E	🕮	HF		
			61	National guidelines are followed for all notifiable medical conditions	I	?🕮	HF		
		10. Infection prevention and control: Monitor whether prescribed infection prevention and control policies and procedures are adhered to							
			62	The National Policy on Infection Prevention and Control is available	E	🕮	NDoH		
			63	Facility has a designated staff member who is assigned the with the infection prevention and control role	E	🕮	HF		
			64	Standard Operating Procedure on infection control standard precautions is available	I	🕮	HF		
			65	All staff has received in-service training on infection control standard precautions that is in-line with the Standard Operating Procedure in the last two years.	E	🕮	HF	**Y**	
			66	Poster on hand washing is displayed above the hand wash basin in every consulting room	I	🕮	HF		
			67	Annual awareness day on hand hygiene is held	I	🕮	HF		
			68	Poster on cough etiquette is displayed in every waiting area	I	🕮	HF		
			69	Staff wear appropriate protective clothing	E	?☺	HF	**Y**	
			70	The linen in use is clean	E	☺	HF		
			71	The linen is appropriately used for its intended purpose	E	☺?	HF		
			72	Waste is properly segregated	E	☺	HF		
			73	Sharps are disposed of in impenetrable, tamperproof containers	V	☺	HF		
			74	Sharps containers are disposed of when they reach the limit mark	V	☺	HF		
			75	Sharps containers are placed on work surface or in wall mounted brackets	E	☺	HF		
			76	An annual risk assessment for infection prevention and control compliance is undertaken by the designated staff member assigned with the infection prevention and control role	I	🕮	HF		

Domain	Sub-domain	No.	Requirement					
DOMA IN 2: PATIENT SAFETY AND CLINICAL GOVERNANCE AND CLINICAL CARE	2. Integrated Clinical Services Management (ICSM)	**11. Patient waiting time:** Monitor whether the facility's prescribed waiting times are adhered to						
		77	The National Policy for The Management Of Waiting Times is available	I	📖	NDoH		
		78	The national target of not more the three hours for time spent in a facility is visibly posted	I	☺📖	HF		
		79	Waiting time is monitored using the prescribed tool	E	📖	HF		
		80	The average time that a patient spends in the facility is no longer than 3 hours	E	📖	HF		
		81	Patients are intermittently informed of delays and reasons for delays in service provision	I	?	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						
		82	The National Patient Experience of Care Guideline is available	E	📖	NDoH		
		83	The results of the yearly Patient Experience of Care Survey are visibly displayed at reception	E	📖	HF		
		84	An average overall score of 70% is obtained in the Patient Experience Of Care Survey	E	📖	HF		
		85	The results obtained from the Patient Experience Of Care Survey are used to improve the quality of service provision	E	📖	HF		
		86	The National Guideline To Manage Complaints/Compliments/Suggestions is available	E	📖	NDoH		
		87	The complaints/compliments/suggestions records show compliance to the National Guideline to Manage Complaints/Compliments/Suggestions	E	📖	HF	Y	
		88	90% of complaints received are resolved	E	📖	HF		
		89	90% of complaints received are resolved within 25 working days	E	📖	HF		
		90	Complaints/compliments/suggestions boxes are visibly placed at main entrance/exit	E	☺	HF		
		91	Official complaint/compliment/suggestion forms and pen are available	E	☺	HF		
		92	A standardised poster describing the process to follow to lodge a complaint, give a compliment or make a suggestion is clearly sign posted next to the complaints/compliments/suggestions box, in at least two local languages	E	☺	HF		
DOMAIN 3: CLINICAL SUPPORT SERVICES	3. Pharmaceuticals and Laboratory Services	**13. Medicines and supplies: Monitor consistent availability of required good quality medicines and supplies**						
		93	SOP for the management and safe administration of medicines is available	I	📖	HF		
		94	Medicine room/dispensary is neat and medicines are stored to maintain quality	I	☺	HF	Y	
		95	There is at least one functional wall mounted room thermometer in the medicine room/dispensary	V	☺	HF		
		96	The temperature of the medicine room/dispensary is recorded daily	V	📖	HF		
		97	The temperature of the medicine room/dispensary is maintained within the safety range	V	📖	HF		
		98	Cold chain procedure for vaccines is maintained	V	📖	HF	Y	
		99	Medicine cupboard or trolley is neat and orderly	I	☺	HF	Y	
		100	The register for schedule 5 and 6 medicine is completed correctly	E	📖	HF		
		101	Electronic networked system for monitoring the availability of medicines is used effectively	E	☺📖	HF	Y	
		102	90% of the medicines on the tracer medicine list are available	V	☺📖	HF	Y	
DOMAIN 3: CLINICAL SUPPORT SERVICES	3. Pharmaceuticals and Laboratory Services	103	Re-ordering stock levels (min/max) are determined for each item on the district/facility formulary	E	☺📖	HF		
		104	Expired medicine is disposed of according to prescribed procedures	E	?	HF		
		105	Basic medical supplies (consumables) are available	E	📖	HF	Y	
		14. Management of laboratory services: Monitor consistent availability and use of laboratory services						
		106	The Primary Health Care Laboratory Handbook is available	E	📖	NDoH		
		107	Required functional diagnostic equipment and concurrent consumables for point of care testing are available	E	☺	HF	Y	
		108	Required specimen collection materials and stationery are available	E	☺	HF	Y	
		109	Specimens are collected, packaged, stored and prepared for transportation according to the Primary Health Care Laboratory Handbook	E	☺	HF	Y	
		110	The laboratory results are received from the laboratory within the specified turnaround times	E	📖	HF	Y	

SOURCE: IDEAL CLINIC DEFNINITIONS, COMPONENTS AND CHECKLISTS, NATIONAL DEPARTMENT OF HEALTH

1.2 REPEAT PATIENT WAITING TIME SURVEY SHOULD BE CONDUCTED

Refer to pre-implementation waiting time study for details.

The waiting time survey will be conducted over the same five days period across all the facilities implementing the ICRM. The number of days over which the survey will be conducted is dependent on the facility patient numbers.

When will the waiting time survey be conducted?

Waiting time must be monitored quarterly. Select a day in the month of the quarter in which the waiting time will be monitored (pre-determined for specific clinic) e.g. second Monday of the month. (Do not select the least busy day of a week!).

Conducting the waiting time survey

i. The patient waiting time tool for monitoring outpatient visits should be utilised in order to measure the patient waiting and service times.

ii. The tool must be attached to the patient's file.

iii. Staff members at every service area must record time of the commencement of service and exit in the respective areas as outlined.

iv. Select the first 100 patients attending the facility, irrespective of diagnosis, on the day that the quarterly waiting time survey will be conducted. In small clinics continue the survey over two to three days until 100 patients have been surveyed.

PATIENT WAITING TIME TOOL

Mark the condition for which patient is attending with an 'X'

ACUTE		CHRONIC				MOTHER AND CHILD		
Minor Ailments	Children (IMCI)	HIV	TB	NCD	Mental health	Well-baby/ EPI	Family planning	ANC /PNC
	Adult							
24 hour Emergency Unit	24 hour MOU							

[1] When the patient enters the door of the facility, the queue marshall (or designated staff member) should record the time.

Area	Enter time			
Time patient enters clinic 1	Hours		Minutes	
Time patient registers at reception desk	Hours		Minutes	
Time patient is allocated patient record	Hours		Minutes	
Time patient completes vital signs	Hours		Minutes	
	Start time		End time	
1st consultation	Hours	Minutes	Hours	Minutes
2nd consultation (2 if referred)	Hours	Minutes	Hours	Minutes
3rd consultation (if referred)	Hours	Minutes	Hours	Minutes
The Pharmacy (if applicable)	Hours	Minutes	Hours	Minutes
Time patient departs clinic 3	Hours		Minutes	

[2] If referred from doctor or nurse to lay counsellor or allied health services (rehabilitation, social worker, nutritionist, etc.).

[3] The last point of contact with service provision.

SOURCE: NATIONAL POLICY ON MANAGEMENT OF PATIENT WAITING TIMES, NOVEMBER 2015, NATIONAL DEPARTMENT OF HEALTH

1.3 CLIENT EXPERIENCES SURVEY

An annual patient experiences survey should be conducted in line with National Guidelines

Conducting the survey

Sampling

All eligible patients seen at the health establishment during the week of the survey should be considered for participation in the survey (sample population).

These patients include:

- All patients who are able to represent themselves i.e. can legally give informed consent for care or patients whose severity of health condition has not affected in any way, their ability to think clearly or be in control of and responsible for their actions – ***compos mentis***
- All patients who are available during the day of data collection and who have experienced care through the healthcare processes performed by the health establishment.

Patients that are to be excluded from participating in the survey are as follows:

- Patients regarded by law, as not having capacity to represent themselves in health related decisions.
- Patients who are too ill or in severe pain, unless they insist on participating.
- Patients who are not mentally fit to properly understand and respond to questions.

Patients who are able to read and write should be allowed to complete the questionnaires on their own, while those that are unable to do so, must be interviewed by a properly skilled data collector, using the same tool.

Sample size

A representative sample of patients that meet the criteria (mentioned in 7.2.1 above) during the survey period will participate in the survey. In order to allow for proper representation, it is recommended that at least ten per cent plus an additional five per cent of all eligible patients complete the questionnaires.

This sample size allows for 95% confidence level and 5% confidence interval. The additional 5% is intended to cater for an envisaged loss of questionnaires (loss to follow-up) due to various reasons, for example, patients terminating their interview or leaving the questionnaires incomplete for various reasons, for example because they had to catch a bus, taxi or train back home.

The sample size is determined using the historical data as follows - see text box for example:

i. Obtain the annual headcount per facility.
ii. Determine the quarterly head count by dividing annual headcount by four.
iii. Multiply the dividend by 0.15 (15%) to obtain the sample size for the quarter.
iv. The product is in turn divided by three to obtain the sample size per month.
v. The quotient may further be divided by four to obtain the sample size per week.
vi. The daily sample size is determined by dividing the quotient with five, six and seven in facilities that operate for five, six or seven days per week respectively.
vii. Acknowledging that the quotient may be comprised by patients that are seen during the day and during the night, the estimated daily headcount is further divided by 40 per cent so as to exclude the numbers that are seen during the night.

QUESTIONNAIRE ON PATIENTS' EXPERIENCE OF CARE FOR OUT-PATIENTS

Date: ____________________

Questionnaire record no. ______

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

QUESTIONNAIRE ON PATIENTS' EXPERIENCE OF CARE FOR OUT-PATIENTS

(*To be completed by* patients at Primary Healthcare facilities and Out-Patient Departments only)

NB! *Patients who are exempted by any legislation or are having a health condition that impedes their ability to represent themselves may be represented by their parents / guardians / family members. Completion of questionnaire should commence from **SECTION 1** while **A** is completed by data collectors.*

A	**IDENTITY OF A HEALTH FACILITY**
Name of Health Facility:	
Type of Health Facility:	
Province:	
District Name:	
Sub-District Name:	
GENERAL INSTRUCTION	**PLEASE MARK THE APPROPRIATE ANSWER WITH X**
SECTION 1	**BIOGRAPHICAL DATA**

1.1	How old are you?		
1.2	Your Sex?	Male	Female
1.3	Have you visited this health facility in the past 12 months?	Yes	No
1.4	It takes me more than two hours travelling in a car, taxi, bus, etc. to get to this health facility.	Yes	No
SECTION 2	**ACCESS TO CARE**		
2.1	Were you ever turned away from this facility without receiving the service you came for?	Yes	No
2.2	Are service times of this facility acceptable to you?	Yes	No
2.3	Were you ever supposed to be transferred from this health facility to another?	Yes	No
	If your answer is "No" to Question 2.3, please proceed (go) to Section 3, Question 3.1		
2.4	Were you given an opportunity to recommend the health facility you preferred to be transferred / referred to?	Yes	No
2.5	Were you happy with the transfer / referral arrangements made for you?	Yes	No
2.6	At the entrance of the health facility, was there a staff member showing people where to access the health service they required?	Yes	No
2.7	Was there a chair/bench for you to sit on while waiting to be attended to?	Yes	No
2.8	Were there notices informing of the location of various health services which are provided by this health facility?	Yes	No
SECTION 3	**AVAILABILITY AND USE OF MEDICINES**		
3.1	Was medicine / treatment prescribed for you today?	Yes	No
	If your answer is "No" to Question 3.1, please proceed (go) to Section 4, Question 4.1		

3.2	Did you receive all your prescribed medicines today?	Yes	No
3.3	Were you informed of how to take medicines / treatment?	Yes	No
SECTION 4	**PATIENT SAFETY**		
4.1	Do you have any form of a disability for which you required assistance?	Yes	No
	If your answer is "No" to Question 4.1, please proceed (go) to Question 4.3		
4.2	Has the health facility assisted you with your disability?	Yes	No
4.3	Were there notices / signage to warn you of obstructions or dangers in the walk-ways?	Yes	No
SECTION 5	**CLEANLINESS**		
5.1	Was drinking water with clean disposable cups available in the waiting area?	Yes	No
5.2	In your opinion, was the health facility generally clean?	Yes	No
5.3	Were there waste disposal bins in which you could toss waste while at any of the service areas you went / passed through?	Yes	No
5.4	Did you **use** the toilet while in this health facility?	Yes	No
If your answer is "No" to Question 5.4, please proceed (go) to Question 5.7			
5.5	Did the toilet facilities have the following?		
5.5.1	Toilet paper	Yes	No
5.5.2	Running tap water	Yes	No
5.5.3	Hand wash basin	Yes	No
5.5.4	Liquid soap dispenser containing liquid soap	Yes	No
5.5.5	Disposable paper towel	Yes	No
5.5.6	Waste disposal bin with lid	Yes	No
5.6	Were toilets in good working order (flushing well)?	Yes	No
5.7	Did you see any of the following pests anywhere while at this facility: cockroaches, rodents, flies, mosquitoes, lice?	Yes	No
SECTION 6	**VALUES AND ATTITUDES**		
6.1	Did staff members introduce themselves to you before attending you?	Yes	No
6.2	Was your permission asked before you were treated?	Yes	No
6.3	Were you given an opportunity to ask questions about your health condition / illness?	Yes	No
6.4	Were you provided with health care services in private where other people could not see or overhear?	Yes	No
6.5	Were staff members generally respectful to patients?	Yes	No
6.6	Do you know how to lodge a complaint?	Yes	No
SECTION 7	**WAITING TIMES**		
7.1	Was there a staff member monitoring the queues?	Yes	No
7.2	Were you informed orally or through pasted notices of how long you would have to wait for services at every service area you passed through?	Yes	No
7.3	Is the general patient waiting time for services acceptable to you?	Yes	No

THANK YOU FOR AGREEING TO PARTICIPATE IN THIS IMPORTANT SURVEY PROJECT.

TO BE COMPLETED BY SURVEY SUPERVISOR

Questions fully completed	**YES**	**NO**	
Reasons for incompleteness			
Conclusion about this questionnaire	Accept it right away	Reject it	
Name, Surname and telephone number of supervisor			

SOURCE: IDEAL CLINIC DEFNINITIONS, COMPONENTS AND CHECKLISTS, NATIONAL DEPARTMENT OF HEALTH

1.4 REVIEW OF RELEVANT DHIS INDICATORS

The following specific indicators should be monitored to depict the trends at the facility level:

	24	TB treatment success rate is at least 85% or has increased by at least 5% from the previous year	E	📖	HF		
	25	TB (new pulmonary) defaulter rate < 5%	E	📖	HF		
	26	Ante-natal visit rate before 20 weeks gestation is at least 67% or has increased by at least 5% from the previous year	E	📖	HF		
	27	Ante-natal patient initiated on ART rate is at least 96% or has increased by at least 5% from the previous year	E	📖	HF		
	28	Immunisation coverage under one year (annualised) is at least 87% or has increased by at least 5% from the previous year	E	📖	HF		

SOURCE: IDEAL CLINIC DEFNINITIONS, COMPONENTS AND CHECKLISTS, NATIONAL DEPARTMENT OF HEALTH

1.5. REVIEW DISTRICT PLANS

Quality improvement

On completion of the various reviews, strengths and challenges will be identified. A root cause analysis should be conducted. A quality improvement programme based on the 'Plan, Do, Study and Act' model should be implemented.

Clinical performance review

Record reviews should be conducted and clinical indicators such as level of hypertension, diabetes and viral loads should be monitored.

Clinical audit

A defined diagnostic condition should be selected. An audit should be conducted based on the National Clinical Audit guidelines

2. EVALUATION

Evaluation is the systematic collection of information about the activities, characteristics and outcomes of a specific programme to determine its merit or worth.

2.1 ESTABLISHING WHY PATIENTS MISS APPOINTMENTS

Appointment scheduling and managing the patient load is a critical component for ensuring the ICSM is functioning optimally. It is therefore important to evaluate potential reasons why patients may miss scheduled appointments, with a view to developing an intervention to improve patient appointment adherence.

Administering the questionnaire

- A person who misses the appointment will be identified in the booking register.
- When this patient returns for his or her visit, the professional nurse will need to administer the questionnaire prior to the patient being consulted.
- A one-month period should be selected annually for interviewing the patients.
- A maximum of 50 patients should be interviewed per facility per annum.
- Informed consent from the patient is required, prior to administering the questionnaire.

Appointment scheduling and managing the patient load is a critical component for ensuring the ICSM is functioning optimally.

INFORMED CONSENT FORM

Informed Consent

I hereby confirm that I have been informed by the interviewer about the nature, conduct, benefits and risks of this study.

I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a research report.

I may, at any stage, without prejudice, withdraw my consent and end my participation in the trial.

I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the research.

I have read and understood the contents of the document.

I understand that I shall receive a signed copy of this document.

Interviewee: Printed Name

Signature Date

I, ... herewith confirm that the above patient has been informed fully about the nature, conduct and risks of the above trial.

Interviewer: Printed Name

Signature Date

Witness:

Printed Name Signature Date

SOURCE: TOOL FOR ELICITING REASONS FOR PATIENTS MISSING SCHEDULED APPOINTMENTS

QUESTIONNAIRE FOR MISSED APPOINTMENTS

QUESTIONNAIRE FOR PATIENT MISSING APPOINTMENTS				
NAME OF PATIENT				
GENDER	**MALE**		**FEMALE**	
AGE				
OCCUPATION				
DIAGNOSIS				
DATE ON WHICH PATIENT MISSED APPOINTMENT				
DATE of attendance				
IS THIS YOUR NEAREST FACILITY FOR CARE?				
HOW MANY YEARS HAVE YOU ATTENDED THis FACILITY?				
WHAT MODE OF TRANSPORT DO YOU USE TO COME TO THE CLINIC				
HOW LONG DOES IT TAKE YOU TO REACH THE CLINIC FROM HOME?				
HOW MUCH DOES IT COST YOU TO COME TO THE CLINIC? (RETURN TRIP)				
WERE YOU INFORMED ABOUT THE DATE OF THE APPOINTMENT?	**YES**		**NO**	
HOW MANY APPOINTMENTS DID YOU MISS THIS YEAR?				
WHAT IS THE MAIN REASON THAT YOU MISSED YOUR APPOINTMENT?				

INDICATE YOUR RESPONSE TO THE FOLLOWING STATEMENTS	YES	NO
I FORGOT ABOUT THE APPOINTMENT		
THE APPOINTMENT WAS ON AN INCONEVENIENT DATE		
I HAD FAMILY COMMITMENTS		
I WAS FEELING WELL AND HAD NO SYMPTOMS		
I WAS TOO ILL TO ATTEND		
I WAS UNABLE TO GET TRANSPORT		
I DID NOT HAVE MONEY FOR TRANSPORT		
I WAS OUT OF TOWN		
I STILL HAD ENOUGH MEDICINE- MEDICINES WERE NOT FINISHED		
I WAS UNABLE TO GET OFF WORK		
I WAS UNABLE TO GET THERE BECAUSE OF WEATHER		
I WAS IN HOSPITAL AT THE TIME		
I WAS THERE AND DID NOT MISS MY APPOINTMENT		
I COULD NOT BE BOTHERED		
DO YOU UNDERSTAND THE NATURE OF THE CONDITION THAT YOU HAVE?		

SOURCE: TOOL FOR ELICITING REASONS FOR PATIENTS MISSING SCHEDULED APPOINTMENTS

2.2 LEVEL OF HYPERTENSION OR DIABETES CONTROL

- *Uncontrolled hypertension*: defined as a patient that is a known hypertensive with a blood pressure of greater than 140/90 on in the last 6 months irrespective of cardiovascular risk factor status
- *Uncontrolled diabetes*: A post-prandial blood glucose level of >11,1 mmol/l or where available HbA_{1AC} > 7%

A survey should be conducted across all hypertension and diabetes patients to determine the level of control.

Lot Quality Assurance Sampling Methodology

Nineteen clinical records (each) from all hypertension and diabetes patients consulted in the facility in the last two months should be reviewed.

NAME OF FACILITY:						
DISTRICT & PROVINCE						
DATE OF VISIT						
PRIMARY DIAGNOSIS				HYPERTENSION/ DIABETES		
NO	AGE	GENDER	PRESCENCE OF CO-MORBIDITY? YES OR NO	CO-MORBIDITY (HIV, ASTHMA,TB, CHOLESTEROL, DIABETES,COPD)	BLOOD PRESSURE (>140/90)	BLOOD SUGAR> 11,1 MMOL
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						

2.3 CLINICAL AUDITS OR RECORD REVIEWS

Clinical audits should be conducted quarterly to evaluate the quality of clinical care. Lot quality assurance Sampling could be employed as the methodology. Nineteen clinical records for pre-determined condition should be selected. The quality of care should be reviewed against the specifications of APC.

CLINICAL AUDIT CRITERIA

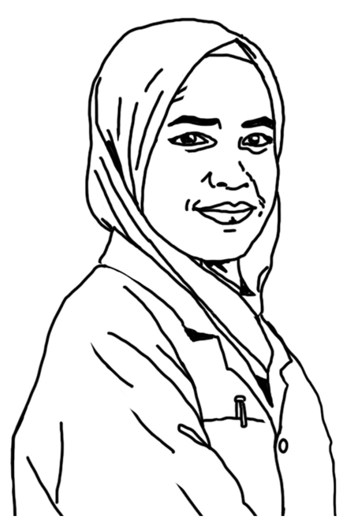
To ensure successful clinical audit, the following criteria should be adhered to:

- Topics chosen for clinical audit should preferably cover aspects of care that are of high risk, high volume or high cost.
- The standards or criteria, against which systematic review of care will take place, should be derived from national, provincial or clinical societal endorsed guidelines, or from good local quality guidelines.
- The sample size chosen should be adequate to produce credible results.
- Clinical audit is action oriented. It should include assessment of input, process and outcome of care, followed by action.
- The required action will be guided by action plans that address the local barriers to change and identify those responsible for service improvement.
- Managers should be actively involved in audit and in particular in the development of the action plans.
- The outcome of action plans should be monitored to ascertain whether improvements in care have been implemented as a result of clinical audit.
- Systems, structures and specific mechanisms should be made available to monitor service improvements once the audit cycle has been completed.
- Each clinical audit should have a local lead to ensure accountability.

Refer to the *National Guidelines for Clinical Audit and Quality Improvement -2009* for further guidance

SECTION EIGHT
CONCLUSION

Focusing on the service delivery component of healthcare, without adequately addressing the health system components, will affect the sustainability of the ICSM implementation. This manual focuses on improving the service delivery component specifically. The Ideal Clinic manual provides a step-by-step guide to implementing Health System Strengthening activities in order to address the challenges identified in the assessment phase, for implementation of ICSM.



The following components of health system strengthening have been addressed in this manual:

Service Delivery: Integrated Clinical Services Management

Human Resources: Staff workload and capacity building

Health Information: Monitoring and Evaluation

Advocacy: Community engagement

The end goal of ICSM is

- **to achieve optimal operational efficiency and improved clinical outcomes**
- **to ensure individuals are supported in taking responsibility for their own health**
- **to have an activated and informed population with regard to their health.**

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ANNEXURES

PATIENT WAITING TIME TOOL

Mark the condition for which patient is attending with an 'X'

ACUTE		CHRONIC				MOTHER AND CHILD		
Minor Ailments	Children (IMCI)	HIV	TB	NCD	Mental health	Well-baby/ EPI	Family planning	ANC /PNC
	Adult							
24 hour Emergency Unit	24 hour MOU							

[1] When the patient enters the door of the facility, the queue marshall (or designated staff member) should record the time.

Area	Enter time			
Time patient enters clinic 1	Hours		Minutes	
Time patient registers at reception desk	Hours		Minutes	
Time patient is allocated patient record	Hours		Minutes	
Time patient completes vital signs	Hours		Minutes	
	Start time		End time	
1st consultation	Hours	Minutes	Hours	Minutes
2nd consultation (2 if referred)	Hours	Minutes	Hours	Minutes
3rd consultation (if referred)	Hours	Minutes	Hours	Minutes
The Pharmacy (if applicable)	Hours	Minutes	Hours	Minutes
Time patient departs clinic 3	Hours		Minutes	

[2] If referred from doctor or nurse to lay counsellor or allied health services (rehabilitation, social worker, nutritionist, etc.).

[3] The last point of contact with service provision.

FACILITY DATA TOOL

DATA ELEMENT	MONTH 1	MONTH 2	MONTH 3	TOTAL FOR 3 MONTHS	AVERAGE PER MONTH	AVERAGE PER DAY
Total headcount						
< 5 years						
> 5 years						
Acute Services						
Emergencies						
Minor ailments (adults)						
Children (IMCI)						
Chronic services						
HIV Pre-ART						
HIV on ART						
HIV stable						
TB initiation phase (1st 2 months)						
TB maintenance						
NCD						
Hypertension						
Diabetes						
Epilepsy						
Asthma/COPD						
Mental Health						
Other						
Preventive and promotive services						
ANC 1st booking						
ANC subsequent visits						
Well-baby						
Immunisation						
Family planning						
Male medical circumcision						
MOU						
Deliveries						
Health support services						
Occupational therapist						
Physiotherapist						
Speech and audiology						
Nutrition						
Social Services						
Eye Health						

HUMAN RESOURCE AND CAPACITY AUDIT

NO	CATEGORY OF STAFF	NUMBER EMPLOYED FULL TIME	NUMBER EMPLOYED SESSIONAL WORK	IF SESSIONAL- NO OF HOURS PER WEEK
1.	Medical practitioner – includes Medical officers, cCommunity service Dr and general practitioners			
2.	Operational manager			
3.	Professional nurses			
4.	Advanced mid-wife's			
4.	Enrolled/staff nurses			
5.	Enrolled nursing assistants			
6.	Pharmacist			
7.	Pharmacy assistants			
8.	Health Promoters			
9	Counsellors- VCT & adherence counsellors			
10.	TB tracers			
11.	Admin clerks			
12.	Facility information officer			
13.	Physiotherapist			
14.	Occupational therapist			
15.	Speech and audiologist			
16.	Dietician			
17.	Nutrition advisor			
18.	Optometrist			

TRAINING COMPLETED									
NAME OF MEDICAL PRACTITIONER/ PROFESSIONAL NURSE	ADULT PRIMARY CARE (APC/PC101)	HIV- ART TRAINING	MENTAL HEALTH	INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI)	MANAGEMENT OF THE NEWBORN	ESSENTIAL MANAGEMENT OF OBSTETRIC EMERGENCIES	BASIC SURGICAL PROCEDURES	BASIC LIFE SUPPORT	ADVANCED LIFE SUPPORT

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