
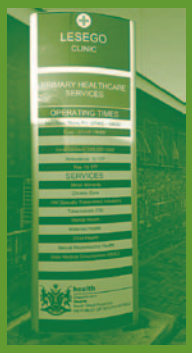



IDEAL CLINIC MANUAL

1 APRIL 2016

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

A long and healthy life for all South Africans

ACKNOWLEDGEMENTS

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

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

The Ideal Clinic programme defines ten components, 32 sub components and 186 elements that must be green, which means that they are present and optimally functional. This Ideal Clinic realisation and maintenance manual has been developed to provide guidance on how to achieve Ideal Clinic status and to maintain such status. The manual is also a tool to assist progressive discipline.

Jeanette Hunter led the development and completion of this manual. The AURUM Institute genereously invested resourses to complete the first draft. Messrs R Morewane, K Mahlako, D Matsebula, Dr K Taole and Mesdames Y Mokgalagadi, M Dichaba and E Shivambu reviewed this draft. Mesdames J Hunter, R Steinhobel, A Jautse and Dr S Asmall sacrificed precious personal time over weekends to complete the final draft.

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

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

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

MP MATSOSO
Director General
7 March 2016

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LIST OF ANNEXURES

LIST OF ACRONYMS

ANC	Antenatal Care
ART	Antiretroviral treatment
CCMD	Centralised Chronic Management of Drugs
CHW	Community Health Worker
CoGTA	Cooperative Governance and Traditional Affairs
DCST	District Clinical Specialist Team
DHIS	District Health Information System
DHMT	District Health Management Team
DHS	District Health Support
DPSA	Department of Public Service and Administration
EML	Essential Medicine List
EPI	Expanded Program on Immunization
HIV	Human Immunodeficiency Virus
HRH	Human Resource for Health
ICSM	Integrated Clinical Services Management
IPC	Infection Prevention and Control
MCWH	Maternal Child Women's Health
Min/max	minimum / maximum
MOU	Maternal Obstetric Unit
MRHS	Male Reproductive Health Services
NCD	Non-communicable diseases
NGO	Non-Governmental Organisation
NHLS	National Health Laboratory Services
PACK	Practical Approach to Care Kit
PC101	Primary Care 101 Guidelines
PDoH	Provincial Department of Health
PEC	Patient Experience of Care
PHC	Primary Health Care
PMDS	Performance Management and Development System
PNC	Prenatal Care
PPTICRM	Perfect Permanent Team for Ideal Clinic Realisation and Maintenance
PSI	Patient Safety Incident
RTHC	Road to Health Chart
SANC	South African Nursing Council
SLA	Service Level Agreement
SOP	Standard Operating Procedure
TB	Tuberculoses
WBPHCOT	Ward Based Primary Health Care Outreach Team
WISN	Workload Indicator Staffing Needs

INTRODUCTION AND BACKGROUND

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

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

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

A standardised questionnaire which is translated into a dashboard (Ideal Clinic components, sub components and elements) is used for tracking progress in PHCs over time. Since 2013 there has been substantial consultation on the dashboard. Feedback from health professionals and managers working at facility, district, provincial and national level improved the dashboard effecting changes from version 1 onwards. This version of the dashboard, version 16, is comprised of 10 components, 32 sub-components and 183 elements. See *Annexure 1*. Version 16 and thus this manual prescribe the minimum elements that should be present in a well-functioning PHC facility. See *Annexure 2*.

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

The average score according to the weights assigned to the 183 elements determines whether Ideal Clinic status is achieved or not. The elements are weighted as Vital (15 elements), Essential (87 elements), and Important (81 elements). In order for a facility to obtain Ideal Clinic status, the facility must at a minimum score 100 percent for elements weighted as Vital, 70 percent for elements weighted as Essential, and 65 percent for elements weighted as Important. This will give the facility silver status. Depending on how a facility performs in a status determination, it will be scored and subsequently categorised as no category achieved, silver (70-79 percent), gold (80-89 percent), platinum (90-99 percent) and diamond (100 percent). The category will only be achieved when the minimum average percentages for Vital, Essential and Important elements have also been achieved. It is therefore important to note that a facility can obtain a high average score (70 to 99 percent) but still fail to obtain an Ideal Clinic category as they have failed to obtain the minimum average score for per weight category.

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

The purpose of this manual

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

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

How to use the manual

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

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

COMPONENT 1: ADMINISTRATION

1. SIGNAGE AND NOTICES

Commitment for Ideal Clinic elements 1–3

Provide information on the location, services, service hours, contact details and search disclaimers of the health facility.

1	All way-finding signage in place
2	Display board reflecting the facility name, service hours, physical address, contact details and service package details is visibly displayed at the entrance of the facility
3	The NO WEAPONS, NO SMOKING, NO ANIMALS (except for service animals), NO LITTERING and NO HAWKERS sign is clearly sign posted at the entrance of the facility

Process

Step 1: Familiarise yourself with the specifications for way-finding signs. See *Annexure 3*.

- do the inspection every six months to check that all way-finding signs for the facility are present and in good condition.

Step 2: In the event of having to replace new, damaged or missing signs, order signs from the sub-district/district manager through supply chain following the relevant provincial protocol.

Step 3: The signs will be installed either by the supplier or district maintenance staff depending on order specifications.

Commitment for Ideal Clinic elements 4–6

Signs and notices are clearly placed throughout the facility.

4	**The vision, mission and values of the district must be visibly displayed**
5	**The facility organogram with contact details of the managers is displayed on a central notice board**
6	**All service areas within the facility are clearly signposted**

Process

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

Step 2: Conduct an inspection of the facility every six months to ensure that all internal signs for the facility are present and in a good condition. See *Annexure 4*.

Step 3: In the event of having to buy new or replace damaged or missing signs, order signs through supply chain management following the relevant provincial protocol.

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

Step 5: All notices like the vision, mission, values and organogram must be attached firmly to a notice board surface. Notices may only be attached to notice boards and to no other surface.

2. STAFF IDENTITY AND DRESS CODE

Commitment for Ideal Clinic elements 7–9

All staff must dress and wear identification tags as required while on duty.

7	There is a prescribed dress code for all service providers
8	All staff members comply with prescribed dress code
9	All staff wear a identification tag

Process

Step 1: Obtain the Staff Dress Code and Insignia specifications from the district. See *Annexure 5* as an example of a Staff Dress Code.

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

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

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

Step 5: Randomly check that the staff on duty are dressed correctly according to the dress code. Check that all staff is wearing prescribed dress code (*Annexure 6*) and identification tags (*Annexure 7*).

3. PATIENT SERVICE ORGANISATION

Commitment for Ideal Clinic element 10

The facility is accessible for people in wheelchairs.

10	There is access for people in wheelchairs

Process

Step 1: Using the wheelchair access requirement checklist make sure that the facility complies with the correct criteria. See *Annexure 8*.

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

Commitment for Ideal Clinic elements 11–13

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

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

Process

Step 1: Schedule a monthly duty roster to assign staff to the help desk/reception.

Step 2: Ensure that the very sick, frail and elderly patients are prioritised.

Step 3: Display notice in predominant language in the waiting area indicating the prioritisation process for frail, elderly and high-risk patients. *See Annexure 9*.

Step 4: Schedule in-service training for ALL staff on prioritisation process. Keep a record of attendance in in-service training book. See *Annexure 10* as an example.

Step 5: Delegate the function of prioritisation process to a specific professional nurse on a daily basis.

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

Step 7: Ensure that functional wheelchairs are available at the facility for use if and when needed.

Step 8: On a weekly basis, monitor the condition of the wheelchairs and order repairs if required

Step 9: If there are no functional wheelchairs available at the facility, order them using the standard provincial protocol.

Step 10: Schedule in-service training for all staff on safety procedures when transporting a patient in a wheelchair. Make a record of attendance in in-service training book. *See Annexure 10* as an example.

4. MANAGEMENT OF PATIENT RECORD

Commitment for Ideal Clinic elements 14–15

Every patient has single record (except for active TB patients) containing correctly captured personal and clinical information.

14	There is a single patient record (except for active TB patients) irrespective of health conditions
15	Patient record content adheres to ICSM prescripts

Process

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

Step 2: Allocate a file number using the filing Standard Operating Procedure that has been approved for the facility.

Step 3: Every patient must have a single patient record (except for active TB patients) that contains all clinical information including laboratory results, copies of referral letters and prescription charts as per ICSM prescripts. See *Annexure 11*.

Commitment for Ideal Clinic elements 16–20

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

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

Process

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

Step 2: Adhere to contents of SOP. See *Annexure 12*.

Step 3: Identify a secure and lockable storage area in or near reception for the filing of patient records.

Step 4: If needed, procure a bulk storage system according to the approved provincial protocol.

Step 5: Schedule in-service training for administrative staff on patient record filing, archiving and disposal procedures. Record attendance in the in-service training book/file. See *Annexure 10* as an example.

Commitment for Ideal Clinic element 21

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

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

Process

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

Step 2: Using the stationery checklist (*Annexure 13*), the facility admin clerk must, on a weekly basis; check that there is sufficient stationery.

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

COMPONENT 2: INTEGRATED CLINICAL SERVICES MANAGEMENT (ICSM)

5. CLINICAL SERVICE PROVISION

Commitment for Ideal Clinic element 22

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

22 The facility has been reorganised with designated consulting areas and staffing for acute, chronic health conditions and preventative health services

Process

Step 1: Using the process flow mapping, see *Annexure 14*, draw up a flow plan for the facility.

Step 2: Flow plan for facility must provide for an area for monitoring vital signs for the three streams of care.

Step 3: Schedule in-service training for all staff on the Integrated Clinical Services Management (ICSM). Record attendance in the in-service training book/file. See *Annexure 15* as an example.

Step 4: Implement process flow as per plan.

Step 5: Mark out flow using colour coding to direct patients.

- acute – orange or red
- chronic health conditions – blue
- preventative health services – green

Note: Facilities that are too small to be segregated into three streams will not be expected to have dedicated consulting areas for acute, chronic health conditions and preventative health services but should still adhere to ICSM principles. This means that patients should be treated holistically and not be sent from one section to another because of co-morbidities. Small facilities that adhere to ICSM principles should be scored green for this element.

Commitment for Ideal Clinic element 23

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

23 Patients are consulted and examined in privacy

Process

Step 1: The induction programme for new staff must include the importance of securing patients' privacy.

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

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

Commitment for Ideal Clinic elements 24–31

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

24	TB treatment success rate is at least 85% or has increased by at least 5% from the previous year
25	TB (new pulmonary) defaulter rate < 5%
26	Antenatal visit rate before 20 weeks gestation is at least 70% or has increased by at least 5% from the previous year
27	Antenatal patients initiated on ART rate is at least 90% or has increased by at least 5% from the previous year
28	Immunisation coverage under one year (annualised) is at least 90% or has increased by at least 5% from the previous year
29	Screening of patients for high blood pressure has increased by 5% since the previous financial year
30	Screening of patients for raised blood sugar has increased by 5% since the previous financial year
31	At least 35% of patients visiting the clinic are screened for mental disorders

Process

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

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

Step 3: Calculate and analyse the data to determine whether the facility is achieving the above targets (see note below on how to conduct the status determination for elements 24 to 31).

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

Notes:

How to conduct the status detemination for element 24

- If the facility obtained the target of 85% the facility scores green (achieved) for the element.
- If the facility did not obtain the target of 85%, there should be at least a 5% increase from the previous financial year:

  The TB programme use the calendar year (January to December) for reporting. The score for element 24 is determined by comparing the outcome of 1 year and 1 quarter ago with the outcome of 2 years and 1 quarter ago.

For example: If you conduct the status determination of a clinic on 10 November 2016 (4th quarter of the year) you compare the TB success rate of the 3rd quarter of 2015 with the TB success rate of the 3rd quarter of 2014.

See table below for examples with values and scores.

Status determination conducted	TB success rate of 1 year and 1 quarter ago	TB success rate 2 of years and 1 quarter ago	Score
10 November 2016 = 4th quarter	3rd quarter 2015 = ≥85%		Green
10 November 2016 = 4th quarter	3rd quarter 2015 = 35%	3rd quarter 2014 = 30%	Green
10 November 2016 = 4th quarter	3rd quarter 2015 = 30%	3rd quarter 2014 = 33%	Red

How to conduct the status detemination for element 25

The TB programme use the calendar year (January to December) for reporting. The score for element 25 is determined by looking at the TB defaulter rate of 6 months (2 quarters) back because the average TB patient is on treatment for 6 months.

For example: If you conduct the status determination on 10 November 2016 (4th quarter) you look at the TB defaulter rate of the 1st quarter of 2016 (January to March 2016).

See table below for examples with values and scores.

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

How to conduct the status detemination for elements 26 to 30

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

    For example:

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

See table below for examples with values and scores.

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

How to conduct the status detemination for element 31

The indicator on screening for mental health disorders has the target of at least 35 per cent because the South African Stress and Health Study of 2004 showed under reporting of the prevalence of mental health. As resources in PHC facilities improve this target will gradually be increased. For the tool to screen patients for mental health disorders see *Annexure 16*.

The score for element 31 is determined by looking at the percentage of patients that were screened for mental disorders:

a) When conducting the status determination during April to June (1st quarter) of a financial year, use the outcome of two financial years ago

b) When conducting status determination during July to March (2nd to 4th quarter) of a financial year, use the outcome of the previous financial year.

See table below for examples with values and scores.

Status determination conducted	Patients screened for mental disorders	Score
10 May 2016	Outcome of 2014/15 financial year = ≥35%	Green
10 July 2016	Outcome of 2015/16 financial year = ≤34%	Red

6. MANAGEMENT OF PATIENT APPOINTMENTS

Commitment for Ideal Clinic elements 32–33

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

32	An ICSM compliant patient appointment system for patients with chronic health conditions and MCWH patients is in use
33	The records of booked patients are pre retrieved at least 24 hours before the appointment

Process

Step 1: Schedule in-service training for clinical and administration staff on patient appointment scheduling. See *Annexure 17*. This will be included in the ICSM training that staff should undergo. Record staff attendance in the in-service training register/book/file. See *Annexure 15* as an example.

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

Step 3: Assign appointment dates and times to patients.

Step 4: As per the patient appointment, the administration staff must retrieve patient records at least 24 hours prior to the appointment.

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

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

Commitment for Ideal Clinic element 34

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

34 Pre-dispensed medication for clinically stable chronic patients is prepared for collection 24 hours prior to collection date/ or patients are enrolled on the CCMDD programme

Process

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

Step 1: Refer to *Annexure 18* on pre-dispensing of chronic medication.

Step 2: Use *Annexure 19* for recording receipt of chronic medication when delivered to a patient to their home by a Community Health Worker (CHW).

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

7. COORDINATION OF PHC SERVICES

Commitment for Ideal Clinic element 35

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

35	Facility renders school health services to schools to schools in its catchment areas

Process

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

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

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

Step 4: The school health team will refer learners on the prescribed form. Provide feedback to the school health team on the prescribed form. See *Annexure 20*.

Step 5: Keep record of learners that were referred and feedback that was provided. See *Annexure 21* as an example.

Commitment for Ideal Clinic element 36

The clinic must have functional WBPHCOT to ensure community based services.

36 The facility refers patients with chronic but stable health conditions to home- and community-care services (WBPHCOT) for support

Process

Step 1: With the support of the district manager ensure that a WBPHCOT services the catchment population of the facility.

Step 2: Refer patients who need follow-up in their homes to the WBPHCOT on the prescribed form. See *Annexure 22* as an example.

Step 3: Keep record/register of patients referred to WBPHCOT

Step 4: Include the WBPHCOT in the facility's quarterly meetings to receive feedback and to give guidance in regard to possible challenges.

Step 5: Avail yourself to meet with WBPHCOT on an ad hoc basis to assist with problems that arise during the course of work.

8. CLINICAL GUIDELINES AND PROTOCOLS

Commitment for Ideal Clinic elements 37–39

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

37	The ICSM compliant package of clinical guidelines is available in all consulting rooms
38	80% of professional nurses have been fully trained on ICSM compliant package of clinical guidelines
39	At least one of the doctors providing services to the clinic have been fully trained on ICSM complaint package of clinical guidelines

Process

Step 1: Do an audit of consulting rooms to check availability of ICSM compliant package of clinic guidelines (soft or hard copy). Use *Annexure 23*.

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

Step 3: Identify an ICSM champion to be trained as a facility trainer on the relevant guidelines by district master trainers.

Step 4: Schedule training for healthcare professionals quarterly and keep attendance registers. See *Annexure 10*.

Note: Soft copies (electronic) of the documents are also acceptable; it does not need to be hard copies.

Commitment for Ideal Clinic elements 40–42

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

40	Resuscitation protocol is available
41	80% of professional nurses have been trained on Basic Life Support
42	All doctors providing services to the clinic have been trained on Basic Life Support

Process

Step 1: Check that the protocol on resuscitation is available at the facility. If the protocol is not available, obtain it at *www.health.gov.za*.

Step 2: Draft a schedule of doctors and nurses who have been trained on Basic Life Support by an accredited provider.

Step 3: Schedule training for nurses and doctors for those who have not been trained as well as for those who are due for their two yearly updates in Basic Life Support.

Step 4: File a copy of the certificates obtained by the staff in Basic Life Support as proof that staff did complete it.

Step 5: Update register of doctors and nurses who have been trained or have updated their Basic Life Support certificate. See *Annexure 24* as an example.

Commitment for Ideal Clinic elements 43–45

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

43 The national policy for Patient Safety Incident Reporting and Learning is available

44 The facility's/district's SOP for Patient Safety Incident Reporting and Learning is available

45 The patient safety incident records show compliance to the national policy for Patient Safety Incident Reporting and Learning

Process

Step 1: Obtain the national policy to manage Patient Safety Incidents from *www.health.gov.za*.

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

Step 3: Assign a staff member to ensure compliance with the facility's SOP to manage Patient Safety Incidents.

Step 4: Complete the Patient Safety Incident Management form when a patient safety incident occurs. See *Annexure 25* as an example.

Step 5: Keep the following records as stipulated in the national policy up to date:

- patient safety incidents register. See *Annexure 26* as an example
- monthly statistics on patient safety incidents. See *Annexure 27* as an example.
  - data on classifications of agents (contributing factors) involved
  - data on classifications of incident type
  - data on classifications of incident outcome
  - indicators for patient safety incidents

Step 6: Identify trends in system failures making use on statistical data on categories of patient safety incidents. Develop quality improvement plans to correct system failures.

Step 7: Do quarterly checks to verify that the facility complies with the policy. See *Annexure 28*.

Commitment for Ideal Clinic elements 46–47

Quality clinical care is maintained by conducting regular clinical audits.

46 The National Clinical Audit guideline is available

47 Clinical audit meetings are conducted quarterly in line with the guideline

Process

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

Step 2: Identify a topic of concern or interest based on the performance of the facility against set targets.

Step 3: Conduct quarterly clinical audit on area of concern or interest.

Step 4: Where there is a need, seek guidance of an expert from the district.

Step 5: Develop a report on findings with recommendations.

Step 6: Provide feedback to relevant staff members.

Step 7: Implement improvements as per agreed time frame.

Step 8: Keep records of all clinical audit activities as outlined in the national guideline.

9. INFECTION PREVENTION AND CONTROL

Commitment for Ideal Clinic elements 48–50

Prevent and control infection.

48	The national policy on Infection Prevention and Control is available
49	There is a staff member who is assigned infection prevention and control role in a facility
50	Staff wear appropriate protective clothing

Process

Step 1: Obtain the national policy on Infection Prevention and Control (IPC) from *www.health.gov.za*.

Step 2: Assign a staff member to ensure compliance with the national policy on Infection Prevention and Control.

Step 3: Conduct spot checks to determine if staff are complying with personal protective clothing requirements. See *Annexure 29*.

Commitment for Ideal Clinic elements 51–52

Prevent and control infection.

51 The linen in use is clean

52 The linen is appropriately used for its intended purpose

Process

Step 1: Orientate all staff on the appropriate use of all linen to ensure that linen is used for its intended purpose at all times. See *Annexure 30*.

Step 2: Determine the stock levels required by a facility and comply with it.

Step 3: In large facilities dedicate a well ventilated room solely for storage of clean linen. In small facilities store linen on a clean and neat rack in store with other supplies and consumables.

Step 4: Keep linen store locked.

Step 5: Order linen as soon as the stock reaches a minimum level.

Commitment for Ideal Clinic elements 53–56

Prevent and control infection.

53 Waste is properly segregated

54 Sharps containers are disposed of when they reach the limit mark

55 Sharps are disposed of in impenetrable, tamperproof containers

56 Sharps containers are placed on a work surface or in wall mounted brackets

Process

Step 1: Train all staff including cleaning staff on the importance of waste handling, segregation and the purpose of the colour categorisation. Make a record of attendance in in-service training book. See *Annexure 10* as an example.

Step 2: Place waste segregation poster in a prominent position at all waste generation points. See *Annexure 31*.

Step 3: Ensure that all sharps containers are placed on work surfaces or placed in a wall mounted bracket while still in use.

Step 4: Designate specific waste storage areas that caters for the different types of waste without cross contamination. These areas must be lockable.

Step 5: Conduct regular spot checks at the facility's waste generation and waste storage areas to determine that correct waste handling and segregation is taking place.

10. PATIENT WAITING TIME

Commitment for Ideal Clinic elements 57–61

Patients are offered treatment in the quickest possible time.

57	The national policy on management of patient waiting time is available
58	The standard waiting time for every service area is visibly posted
59	Waiting time is monitored using the prescribed tool
60	The average time that a patient spends in the facility is not longer than three hours
61	Patients are intermittently informed of delays and reasons for delays

Process

Step 1: Obtain the national policy on waiting time from *www.health.gov.za*.

Step 2: Visibly display the average patient waiting time for the facility at the reception area of the facility.

Step 3: Patients are intermittently informed of any delays and improvement measures that are taken.

Step 4: One day in the month, monitor compliance with the pre-determined patient waiting time. See *Annexure 32*. If the facility's average waiting time exceeds three hours, establish which service areas cause bottle necks.

Step 5: Address deficiencies in bottle neck areas.

11. PATIENT EXPERIENCE OF CARE

Commitment for Ideal Clinic elements 62–65

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

62	The National Patient Experience of Care Guideline is available
63	The results of the yearly Patient Experience of Care survey are visibly displayed at reception
64	An average overall score of 60% percent is obtained in the patient experience of care survey
65	The results obtained from the Patient Experience of Care survey are used to improve the quality of service provision

Process

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

Step 2: Sub district/district manager facilitates in line with peer review principles (to minimise conflict of interest) staff members to conduct the annual survey.

Step 3: Conduct the survey as stipulated in the National PEC guideline.

Step 4: Publish and display the results of the survey at the reception area. See *Annexure 33*.

Step 5: Develop the operational plan to respond to the results of the survey.

Step 6: Sign and date the commitment. See *Annexure 34*.

Step 7: Implement the plan.

Commitment for Ideal Clinic elements 66–70

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

66	The national policy to manage complaints/compliments/suggestions is available
67	The facility's/district's Standard Operating Procedure to manage complaints/ compliments/suggestions is available
68	The complaint, compliments and suggestions records show compliance to the national policy to manage complaint/compliments/suggestions
69	90% of complaints received are resolved
70	90% of complaints received are resolved within 25 working days

Process

Step 1: Obtain the national policy to manage complaints, compliments and suggestions from *www.health.gov.za*.

Step 2: Develop a facility/district specific Standard Operating Procedure (SOP) using the National Guideline for Developing a Facility Specific SOP to Manage Complaints, Compliments and Suggestions.

Step 3: Assign a staff member to ensure compliance with the facility's SOP to manage complaints, compliments and suggestions.

Step 4: Follow the procedure to manage complaints/compliments/suggestions whenever complaints/ compliments/suggestions are received.

Step 5: Keep the following records as stipulated in the National Policy up to date:

- letters of complaint
- redress letters and/or minutes of redress meeting
- complaints, compliment and suggestion registers. See *Annexure 35*
- monthly statistics on complaints, compliments and suggestions. See *Annexure 36*
  - data on classifications of complaints
  - indicators for complaints.

Step 6: Identify trends in system failures making use on statistical data on categories of complaints. Develop quality improvement plans to correct system failures.

Step 7: Do quarterly checks to verify that the facility comply with the policy. See *Annexure 37.*

Commitment for Ideal Clinic elements 71–73

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

71 Complaints/compliments/suggestions boxes are visibly placed at main entrance/exit

72 Official complaint/compliments/suggestion forms and pen are available

73 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

Process

Step 1: Familiarise yourself with specifications for the complaints, compliment and suggestion box. See *Annexure 38*.

Step 2: Order the box if there is not one available.

Step 3: Identify a visible and accessible location at the entrance and or exit of the facility for placement of the box. Install the box at the identified location.

Step 4: A pen and sufficient copies of the complaints, compliments and suggestions forms must be available from the person managing complaints, compliments and suggestions or next to the box. See *Annexure 39*.

Step 5: Print a poster that describes the process to follow if a patient wants to lodge a complaint, give a compliment or make a suggestion. The poster must be available in English and at least one other local language. See *Annexure 40*.

Step 6: Place the posters next to the complaints/compliments/suggestion box.

COMPONENT 3: MEDICINES, SUPPLIES AND LABORATORY SERVICES

12. MEDICINES AND SUPPLIES

Commitment for Ideal Clinic elements 74–79

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

74	There is at least one wall mounted room thermometer in the medicine room/ dispensary
75	The temperature of medicine room/dispensary is recorded daily
76	The temperature of the medicine room/dispensary is maintained within the safety range
77	There is a thermometer in the medicine refrigerator
78	The temperature of the medicine refrigerator is recorded twice daily
79	The temperature of the medicine refrigerator is maintained within the safety range

Process

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

Step 2: Check availability and functioning of refrigerator for the storage of thermolabile medicines. If there is no refrigerator in medicine room/dispensary, or the refrigerator is not in good working order, place an urgent procurement/works order for procurement/repair using the applicable procurement procedure.

Step 3: Hang/place the refrigerator thermometer in the centre of the fridge.

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

Step 5: Ensure availability of monthly temperature record charts to record the room and refrigerator temperatures, see *Annexure 41*.

Step 6: Allocate a staff member to record temperatures for the room and the refrigerator daily using the temperature record charts. Also check that there are no non-medicine items (such as food) kept in the refrigerator.

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

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

Step 9: Review the refrigerator temperature record chart weekly to ensure the temperature range for the medicine refrigerator is within the safety range (between 2 - 8°C) at all times.

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

Step 11: If the air conditioner is not working use a fan to keep the room cool.

Note: When conducting a status determination, check records for temperature control charts for the previous month.

Commitment for Ideal Clinic elements 80–81

Ensure consistent availability of essential PHC medicines.

80 90% of the tracer medicines are available

81 Re-order stock level (min/max) is determined for each item on the provincial/district formulary

Definitions of terms used in this section:

Formulary

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

Essential medicine list

The South African PHC STGs/EML, see *Annexure 42*, provides a list of medicines, together with guidelines guiding rational medicine use. It provides a foundation for supporting preventative and curative healthcare services at primary healthcare level. Essential medicines are those that satisfy the priority healthcare needs of a population. They are selected with respect to disease prevalence and public health importance, with selection decisions made through the review of clinical evidence considering efficacy, safety, quality and comparative cost-effectiveness

Tracer medicines list

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

Process

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

Step 2: The facility manager or nurse designated to manage medicine in the facility must:

- ensure that all medicines aligned to the approved provincial/district formulary (extracted from the PHC STGs/EDL) are available at the facility.
- ensure all tracer medicines is monitored twice weekly using *Annexure 43*.
- check the medicine room/dispensary, and medicine trolleys/cupboards to ensure stock is stored according to best practice following First In First Out (FIFO)/First Expired First Out (FEFO) stock rotation principles.

Step 3: Determine reorder levels for stock items as per standard operating procedure.

Step 4: Check stock in the medicine room and/or dispensary weekly to ensure stock levels are maintained within the minimum/maximum range for replenishment.

- for facilities with an electronic system for monitoring availability of medicine, report stock levels as per approved schedule and standard operating procedure.

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

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

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

Commitment for Ideal Clinic element 82

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

82 Expired medicine is disposed of according to prescribed procedures

Process

Step 1: Check the medicine room/dispensary, and medicine trolleys/cupboards to ensure that expired stock is removed following First in First Out (FIFO)/First Expired First Out (FEFO) stock rotation principles.

Step 2: Medicines that will expire within three months or are unlikely to be used before expiry must be returned to the immediate supplier of stock or rotated to other facilities that could use the medicines before expiry and the supervising pharmacist informed accordingly.

Step 3: Details of medicine that have expired must be recorded before they are sent for destruction. See national guideline for destruction and disposal of medicines and scheduled substances for the forms to be completed

Step 4: All records must be maintained in a file.

Step 5: After recording expired stock seal the expired medicine securely with a copy of the record.

Step 6: All expired stock items must be stored separately from usable stock in accordance with the applicable standard operating procedure.

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

Step 8: The supervising pharmacist must ensure that the expired medicine is destroyed and disposed of in accordance with applicable legislation and supply chain procedures. See national guideline for destruction and disposal of medicines and scheduled substances available at *www.health.gov.za*.

Note: When conducting a status determination, ask the facility manager or nurse designated to manage medicine to explain the process to be followed at facility level for disposal of expired medicines. The element is scored green if he/she explains the process correctly.

Commitment for Ideal Clinic element 83

Manage minor injuries at Primary Health Care facilities.

83 Basic surgical supplies (consumables) are available

Process

Step 1: Determine re-order levels for each item on the list for basic surgical supplies. See *Annexure 44*.

Step 2: Monitor stock of basic surgical supplies weekly.

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

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

13. MANAGEMENT OF LABORATORY SERVICES

Commitment for Ideal Clinic elements 84–88

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

84	The Primary Health Care Laboratory Handbook is available
85	Required functional diagnostic equipment and concurrent consumables for point of care testing are available
86	Required specimen collection materials and stationery are available
87	Specimens are collected, packaged, stored and prepared for transportation according to the Primary Health Care Laboratory Handbook
88	The laboratory results are received from the lab within the specified turnaround times

Process

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

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

Step 3: Ensure all required functional diagnostic equipment and concurrent consumables for point of care testing are available. See *Annexure 45*.

Step 4: Ensure that required specimen collection materials and stationery are available. See *Annexure 46*.

Step 5: Induct all new staff on the NHLS process on handling specimens correctly as outlined in the manual. Conduct spot checks to make sure the process is being followed correctly. See *Annexure 47*.

Step 6: Using the manual or electronic tracking form check if patient laboratory results have been received within the specified time frame. See *Annexure 48*.

Step 7: If the results have not been received within the specified turnaround times, follow up with the laboratory.

Step 8: File all results appropriately in patient record within 24 hours of receipt.

COMPONENT 4: HUMAN RESOURCES FOR HEALTH

14. STAFF ALLOCATION AND USE

Commitment for Ideal Clinic elements 89–91

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

89	Staffing needs have been determined in line with WISN
90	Staffing is in line with WISN
91	A facility with a workload of more than 150 patients per day has a dedicated facility manager whose work content consists of approximately 80% management and 20% clinical work

Process

Step 1: Contact the sub-district/district to arrange a date for the human resource staff to conduct the WISN assessment.

Step 2: Prepare all the information on the staff and clinic services that will be needed during WISN assessment.

Step 3: Inform your staff of the planned date, provide necessary information and orientate them on the expected procedure for that day.

Step 4: If the report has not been received after one week of completion of the WISN assessment, follow up with the sub-district/district manager.

Step 5: After receiving the report, develop the Ideal Organogram for your facility using the WISN assessment findings.

Step 6: Obtain approval of the Ideal Organogram from the district manager.

Step 7: Should there be surplus staff in your facility, plan with district manager for redeployment.

Step 8: Should there be a need for additional staff, write a request to the district manager for the posts to be created, funded and filled.

Step 9: Participate in the recruitment and selection process as required.

Step 10: District manager to appoint a dedicated manager for facilities that have a headcount of more than 150 patients per day. Content of the job description and performance agreement must be in line with the approximately 80 per cent management and 20 per cent clinical work principle.

Note: Facilities that do not see more than 150 patients per day will score green on this element 91 if they do not have a dedicated clinic manager.

Commitment for Ideal Clinic element 92

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

92 Work allocation schedule is signed by all staff members

Process

Step 1: Complete the work allocation schedule daily, weekly or monthly as appropriate for your clinic. See *Annexure 49*.

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

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

Commitment for Ideal Clinic elements 93–94

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

93 Leave policy is available

94 An annual leave schedule is available

Process

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

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

- Explain the policy contents clearly to the staff so that they understand the leave process, emphasising the need for approval prior to going on leave, unless in an emergency situation.
- Staff to sign acknowledgment indicating that they are aware of the policy and its application. See *Annexure 50*.

Step 3: Draw up an annual leave schedule for all staff members taking into account the service needs of the facility. See *Annexure 51*.

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

15. PROFESSIONAL STANDARDS AND PERFORMANCE MANAGEMENT DEVELOPMENT (PMDS)

Commitment for Ideal Clinic element 95

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

95	There is an individual Performance Management Agreement for each staff member

Process

Step 1: Obtain the PMDS policy from the district.

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

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

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

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

Step 5: Performance appraisal to be conducted quarterly using the PMDS evaluation templates. Evaluation templates available on the DPSA website.

Note: Even if personnel records are kept at a central location, copies of staff PMAs and performance review documents must be available at the facility. Good practice prescribes that individual staff members and the facility manager refers to these documents regularly to track performance and staff development needs.

Commitment for Ideal Clinic elements 96–97

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

96 Continued staff development needs are determined for the current financial year and submitted to the district manager

97 Training records reflect that planned training is conducted as per the district training programme

Process

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

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

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

Step 4: Record all training in a register. See *Annexure 10* as an example.

Commitment for ideal Clinic elements 98–99

Staff are disciplined and are committed to providing quality health services.

98 The disciplinary procedure is available

99 The grievance procedure is available

Process

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

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

Step 3: All staff must sign acknowledgement that they have been informed of both procedures and understand it. See *Annexure 50*.

Commitment for Ideal Clinic elements 100–101

Staff work in a positive work environment.

100 Staff satisfaction survey is conducted annually

101 The results of the staff satisfaction survey is used to improve the work environment

Process

Step 1: In cooperation with the district human resource management unit, conduct the yearly staff satisfaction survey. As an example see *Annexure 52*.

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

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

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

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

16. ACCESS TO MEDICAL, MENTAL HEALTH, AND ALLIED HEALTH PRACTITIONERS

Commitment for Ideal Clinic elements 102–112

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

102 Patients have access to a medical practitioner

103 Patients have access to oral health services

104 Patients have access to occupational therapy services

105 Patients have access to physiotherapy services

106 Patients have access to dietetic services

107 Patients have access to social work services

108 Patients have access to radiography services

109 Patients have access to ophthalmic service

110 Patients have access to mental health services

111 Patients to speech and hearing services

112 Patients have access to a pharmacist

Process

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

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

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

Step 4: Describe in the facility's Standard Operating Procedure (SOP) for patient referrals the various referral paths (as mapped out in step 1) to be followed to allow access for patients to the services that cannot be provided by the facility as described in elements 105 to 115. Make suitable arrangements for patients that must be referred.

COMPONENT 5: SUPPORT SERVICES

17. FINANCE AND SUPPLY CHAIN MANAGEMENT

Commitment for Ideal Clinic elements 113–114

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

113 The facility has a supply chain system for general supplies

114 Facility manager uses the supply chain system to ensure adequate replenishment of supplies

Process

Step 1: The district Supply Chain Management (SCM) unit to ensure that the facility has access to the automated system.

Step 2: Set minimum and maximum value for each item based on facility use.

Step 3: Replenish item as indicated by the system.

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

Step 5: Keep all source documents safely.

18. HYGIENE AND CLEANLINESS

Commitment for Ideal Clinic elements 115–120

The entire facility is clean at all times.

115 Cleaners are appointed in line with WISN guidelines
116 All cleaners have been trained on cleaning
117 All work completed is signed off by cleaners
118 Cleaning materials are available
119 Intensive cleaning of a facility is conducted during the least busy times
120 All service areas are clean

Process

Step 1: Determine the number of required cleaners according to WISN guidelines. See *Annexure 53*.

Step 2: Appoint the required number of cleaners as per the approved organogram.

Step 3: Ensure that cleaners have been appropriately trained and are fully aware of their duties. This includes orientation of new cleaners.

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

Step 4: Identify, schedule and record additional training needs of cleaners.

Step 5: Maintain records of training of each cleaner. See *Annexure 10* as an example .

Step 6: Obtain the prescribed list of non-negotiable cleaning materials (*Annexure 54*) and ensure that facility has cleaning material at all times.

Step 7: Ensure that cleaning is in line with expected standards and that cleaners take responsibility for their allocated areas through appropriate supervision and sign-off on check list. See *Annexure 55* as an example.

- Schedule the intensive cleaning times so that they do not clash with the busy times of the facility. See *Annexure 56* as an example.
- Conduct daily inspections of the service areas of the facility using the Cleaning Inspection Checklist. See *Annexure 57*.
- If any areas are not clean, discuss with the relevant cleaner and get them to clean again.
- Instruct cleaners to inform the facility manager immediately of any repairs required.

Step 8: File the checklists (supervision and cleaning) in the cleaning file.

Step 9: Instruct cleaners to close taps properly and switch off unnecessarily lights.

Commitment for Ideal Clinic element 121

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

121 Clean running water, toilet paper, liquid hand wash soap and disposable hand paper towels are available

Process

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

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

Step 2: Conduct a weekly inspection of all consumables to ensure the correct quantity is available. See *Annexure 58*.

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

Commitment for Ideal Clinic elements 122–123

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

122 Sanitary and health care waste disposal bins are lined with red plastic bin liners and have functional lids

123 General disposal bins are lined with transparent or black plastic bin liners and have functional lids

Process

Step 1: Obtain checklist for sanitary disposal bins and general waste bins. See *Annexure 59* and *Annexure 60*.

Step 2: Display on notice board in dirty utility room the instructions for the correct use of coloured bin liners to be used for sanitary disposal and general waste management.

- sanitary and medical waste disposal bins must be lined with red plastic bin liners
- general disposal bins must be lined with transparent or black plastic bin liners
- all disposal bins must be clean and intact
- broken disposal bins must be replaced with new ones

Step 3: Place the sanitary, health care waste and general disposal bins in the appropriate areas.

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

Step 4: Conduct spot checks on the status of the sanitary disposal bins and the general waste bins to ensure compliance to the infection control measures. Non-functional sanitary disposal bins and general waste bins (broken and/or damaged) must be replaced by ordering new ones.

Step 5: Instruct the cleaners to inform the facility manager immediately if the consumable stock is getting close to the minimum level.

Commitment for Ideal Clinic element 124

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

124 All toilets are clean, intact and functional

Process

Step 1: Obtain checklist for functional toilet status.

Step 2: Conduct a spot check of the toilets in your facility to see that they are intact and functional. See *Annexure 61*.

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

Step 4: Ensure prompt repairs of broken toilets.

Commitment for Ideal Clinic element 125

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

125 The exterior of the facility is aesthetically pleasing and clean

Process

Step 1: Appoint the required number of groundsmen as per the approved organogram.

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

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

Step 3: Maintain records of training of each groundsmen. *Annexure 10* as an example.

Step 4: Do spot checks of the exterior to check whether the facility is neat and clean. See *Annexure 62*.

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

Commitment for Ideal Clinic elements 126–128

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

126 Waste is stored in access-controlled rooms

127 A signed waste removal service level agreement between the health department and the service provider is available

128 Waste is removed in line with the contract

Process

Step 1: Obtain the SOP (hard or soft copy) for waste management. *Annexure 63*.

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

Step 3: Maintain records of training of all staff. See *Annexure 10* as an example.

Step 4: Place Waste Categorisation Schedule (*Annexure 31*) in the dirty utility room.

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

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

Step 7: Ensure that all waste are stored in an access controlled general and healthcare waste storage areas.

- If designated area is not available or conforming to required standard, place a works order.

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

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

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

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

19. SECURITY

Commitment for Ideal Clinic elements 129–132

Patient and staff safety is assured at all time.

129	Perimeter fencing is intact
130	Separate lockable functioning pedestrian entrance/gate
131	Parking for staff on the facility premises
132	There is a standard security guard room

Process

Step 1: Conduct a monthly walk about to ensure that perimeter fencing is intact, gates are functioning and the guard room is neat and tidy. Guard room must conform to the standards. See *Annexure 64*.

Step 2: If the clinic does not have parking for staff this must be requisitioned through the district/provincial infrastructure unit.

Step 3: Inform the district/provincial infrastructure unit in writing of identified weaknesses.

Step 4: Keep a copy of correspondence with district infrastructure in this regard.

Note: Facilities with the structural make-up that render perimeter fencing, pedestrian gate and separate guard house impossible/unnecessary e.g. in a multi story building in a city will score green on element 129, 131 and 132 even if they do not have a perimeter fence, pedestrian gate or a guard house.

Commitment for Ideal Clinic element 133

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

133 A signed copy of the service level agreement between the security company and the provincial department of health is available

Process

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

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

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

Step 4: Monitor if security services complies with the requirements of the SLA.

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

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

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

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

20. DISASTER MANAGEMENT

Commitment for Ideal Clinic element 134

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

134 Functional firefighting equipment is available

Process

Step 1: Ensure that functional fire fighting equipment (*Annexure 65*) that should be in your facility is available.

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

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

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

Step 5: A record must be kept of the services conducted. See *Annexure 66* as an example. The facility manager must remind the service provider in good time of the next scheduled service date.

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

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

Commitment for Ideal Clinic elements 135–136

The clinic is at ready for emergency evacuation all times.

135 The emergency evacuation procedure is practiced annually

136 Deficiencies identified during the emergency evacuation drill are addressed

Process

Step 1: Developed emergency evacuation plan.

Step 2: Conduct yearly evacuation drill. ***Note:*** **No critical patient must be left unattended during the evacuation practice.** Allocate a trained staff member to attend to them.

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

Step 3: Debrief and feedback to staff.

Step 4: Draw up an emergency evacuation drill practice report (see *Annexure 67* as an example) and file. This report must include recommendations for improvement if applicable.

Step 5: Plan and implement remedial action within two weeks.

Step 6: Rerun the evacuation practice if necessary.

COMPONENT 6: INFRASTRUCTURE AND SUPPORT SERVICES

21. PHYSICAL SPACE AND ROUTINE MAINTENANCE

Commitment for Ideal Clinic element 137

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

137 Clinic space accommodates all services and staff

Process

Step 1: Determine additional space or renovations required based on population to be served and PHC package of services provided. See *Annexure 68*.

Step 2: Prepare and submit a motivation to district office for additions/renovations.

Step 3: Make regular follow up with the district manager in this regard.

Commitment for Ideal Clinic element 138

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

138 The facility's infrastructure is maintained

Process

Step 1: Using *Annexure 69*, compile a checklist of major infrastructure repairs and maintenance work required.

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

Step 3: As soon as items for minor repair are identified, complete and submit a works order. Keep record of orders submitted and track progress. See *Annexure 70* as an example.

Step 4: If no action has been taken within one week, escalate to sub-district/district.

22. ESSENTIAL EQUIPMENT AND FURNITURE

Commitment for Ideal Clinic elements 139–140

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

139 Furniture is available and intact in service areas

140 Essential equipment is available and functional in every consulting room

Process

Step 1: Obtain the list for the furniture and essential equipment required in the consulting rooms

- basic consulting room furniture (*Annexure 71*).
- essential equipment (*Annexure 72*).

Step 2: Using the lists for furniture and essential equipment required in the consulting room, conduct a quarterly stock taking and ensure that all the items are available.

Step 3: Ensure that missing items are budgeted for.

Step 4: Order missing items using the standard procurement procedure.

Step 5: Immediately follow up if items were not received on the indicated date.

Commitment to Ideal Clinic elements 141–144

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

141 Resuscitation room is equipped with functional basic equipment for resuscitation

142 Restore the emergency trolley daily or after every time it was used

143 There is a sterile emergency delivery pack

144 There is a sterile pack for minor surgery

Process

Step 1: Obtain standardised list of basic requirements for resuscitation, emergency trolley, and emergency delivery.

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

- resuscitation room – *Annexure 73*
- emergency trolley – *Annexure 74*
- sterile emergency delivery pack – *Annexure 75*
- equipment for minor surgery – *Annexure 76*

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

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

Commitment for Ideal Clinic element 145

Oxygen must be consistently available to patients when needed.

145 Oxygen cylinder with pressure gauges available in resuscitation/emergency room

Process

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

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

Step 3: Using a check sheet (See *Annexure 77* as an example), the designated staff member, on a daily basis, ensures that the oxygen level is as prescribed.

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

Commitment to Ideal Clinic element 146

The facility uses space optimally.

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

Process

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

Step 2: If there are any items of equipment found to be beyond repair, have this condemned and disposed of. Using an asset disposal form. See *Annexure 78* as an example.

Step 3: Update asset register accordingly.

23. BULK SUPPLIES

Commitment for Ideal Clinic elements 147–148

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

147 There is constant supply of clean, running water to the facility

148 There is emergency water supply in the facility

Process

Step 1: In cooperation with the local municipality ensure that there is always clean water available at the facility. This can be in the form of:

- water piped from a main water line
- water tanks that are regularly filled by the local municipality
- tanks on trailers that are brought to the facility on a regular basis by the local municipality.

Step 2: The 24-hour contact number of the local municipality's water supply department must be prominently displayed on the facility's notice board together with other emergency numbers of essential services.

Step 3: If the water supply is problematic in any way (no supply, low tank levels, etc.), log a call with the local municipality to take corrective action.

Step 4: A tank should be available for emergency back-up water supplies when normal water supplies are disrupted.

Step 5: The water level of the tank should be checked at least every fortnight.

Note: Facilities were water supply is disrupted less than once a year can score green for element 148 even if they have no back-up water supply.

Commitment for Ideal Clinic elements 149–150

Facilities must have uninterrupted electricity supply.

149 There is a functional back-up electrical supply

150 The back-up electrical power supply is checked weekly to determine its functionality

Process

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

Step 2: If back-up electricity to the facility is in the form of a generator, assign a staff member to check the fuel levels on a weekly basis and after every use.

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

Commitment for Ideal Clinic element 151

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

151 The sewerage system is functional

Process

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

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

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

24. ICT INFRASTRUCTURE AND HARDWARE

Commitment for Ideal Clinic element 152

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

152 There is a functional telephone system in the facility

Process

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

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

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

Commitment for Ideal Clinic elements 153–155

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

153 There is a functional computer

154 There is a functional printer connected to the computer

155 There is web access

Process

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

Step 2: Update the asset register accordingly.

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

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

Step 5: Ensure that the facility has internet access.

COMPONENT 7: HEALTH INFORMATION MANAGEMENT

25. DISTRICT HEALTH INFORMATION SYSTEM (DHIS)

Commitment for Ideal Clinic elements 156–161

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

156 Facility performance in response to burden of disease of the catchment population, is displayed and is known to all clinical staff members

157 District Health Information Management System policy available

158 Professional nurses and data capturers trained on the facility level Standard Operating Guidelines for data management

159 Relevant DHIS registers are available and are kept up to date

160 Facility submitted all monthly data on time to the next level

161 There is a functional computerised patient information system

Process

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

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

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

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

Step 5: Maintain records of training. See *Annexure 10* as an example.

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

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

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

Step 9: Sign off data report.

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

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

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

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

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

COMPONENT 8: COMMUNICATION

26: INTERNAL COMMUNICATION

Commitment for Ideal Clinic element 162

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

162 There are sub district/district quarterly facility performance review meetings

Process

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

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

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

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

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

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

Commitment for Ideal Clinic element 163

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

163 There is at least a quarterly meeting held within the facility

Process

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

Step 2: Include quarterly meeting dates on the Annual Facility Calendar. See *Annexure 79* as an example.

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

Step 4: Develop an agenda for the meeting. See *Annexure 80* as an example.

Step 5: All staff who attended the meeting must sign the attendance register. See *Annexure 81* as an example.

Step 6: Designate a staff member to take minutes.

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

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

Commitment for Ideal Clinic element 164

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

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

Process

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

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

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

Step 4: Get all staff members to sign the acknowledgement form. Attach this to the back of the new policy or notice and file the document. See *Annexure 50* as an example.

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

27: COMMUNITY ENGAGEMENT

Commitment for Ideal Clinic elements 165–166

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

165 There is a functional clinic committee

166 Contact details of clinic committee members are visibly displayed

Process

Step 1: Using National Clinic Committee Guidelines (*www.health.gov.za*) understand the roles, responsibilities and activities of the clinic committee as well as how to get a functional clinic committee established.

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

Functional implies that:
✓ clinic committee members have been officially appointed in writing by the MEC for Health in the province
✓ clinic committee has required number of members
✓ meeting schedule is available
✓ regular meetings are held
✓ minutes of meetings are available

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

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

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

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

Step 6: In cooperation with the chairperson of the clinic committee:

- develop a schedule of monthly meetings
- request training for clinic committee members from the district
- attend clinic committee meetings, ensure that agenda is developed, register is kept and minutes are taken. See *Annexure 80*/*Annexure 81* as an example
- follow up actions arising out of clinic committee meetings.

Commitment for Ideal Clinic element 167

Promote community ownership of the facility and its functions while strengthening health promotion and disease prevention in the community.

167 The facility has an annual open day

Process

Step 1: In consultation with facility staff and community leaders plan for open days. See an example of suggested services and activities for an open day. See *Annexure 82* as an example.

Step 2: Log dates of the open day in the annual calendar to be displayed on the staff notice board. See annexure *Annexure 79* as an example.

Step 3: In cooperation with the clinic committee seek support from relevant sources.

Step 4: Ensure the necessary communication with stakeholders required for a successful open day.

Step 5: On the day of the event oversee the setup and activities including various health screening.

Step 6: Compile a report of the event including relevant statistics of screenings conducted.

Step 7: Submit the report to the sub-district/district and file the report.

COMPONENT 9: DISTRICT HEALTH SYSTEM SUPPORT

28: DISTRICT HEALTH SUPPORT

Commitment for Ideal elements 168–169

The district supports the facility through Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) to function in line with the national quality standards. The district must provide comprehensive support on all aspects of the management of the facility.

168 There is a health facility operational plan in line with district health plan

169 The district Permanent Perfect Team for Ideal Clinic Realisation and Maintenance (PPTICRM) visits the clinic at least twice a year to record the Ideal Clinic Realisation and Maintenance status and to correct weaknesses

Process

Step 1: Develop a facility operational plan in line with the district health plan.

Step 2: The PPTICRM, in cooperation with the facility manager, plan and agree on the dates for visits to provide the necessary support to the facility with regard to all the components, sub components and elements of the Ideal Clinic.

Step3: Conduct the status determination and capture the results on the Ideal Clinic software.

Step 4: Using the generated quality improvement plan correct the weaknesses immediately.

Step 5: The status of the facility as well and the corrective actions must be presented at the quarterly district performance review meetings.

29: EMERGENCY PATIENT TRANSPORT

Commitment for Ideal Clinic elements 170–171

The facility must have access to emergency medical services (EMS) transport.

170 There is a pre-determined EMS response time to the facility

171 EMS respond according to the pre-determined response time

Process

Step 1: Obtain the norm for the response time relevant to the facility from the sub-district/district Emergency Medical Services (EMS) manager.

Step 2: Keep a register of actual emergency transport response time. See *Annexure 83* as an example.

- The staff member requesting patient emergency transport must record the patient name, date and time patient transport was requested, referral destination, and date and time of patient collection in the ambulance response time.
- Calculate and record the response times in the register.
- On a monthly basis monitor the trend in response time to determine whether the EMS complies with the norm.

Step 3: Escalate to the sub-district/district office if there are consistently long response times or for serious incidents where response time was poor. The district management must communicate the course of redress to the facility.

Step 4: If no response to the follow-up has been received from the sub-district/district office within seven days then escalate the query to the next level.

30: REFERRAL SYSTEM

Commitment for Ideal Clinic elements 172–174

Facility must have access to a rational and responsive referral system to ensure continuity of care between different levels of health service.

172 The National Referral Policy is available

173 The facility's Standard Operating Procedure for referrals is available and sets out clear referral pathways

174 There is a referral register that records referred patients

Process

Step 1: Obtain a copy of the National Referral Policy (*www.health.gov.za*).

Step 2: Develop the facility's SOP including referral path ways for your facility that is in line with the National Referral Policy.

Step 3: Schedule orientation and training for all healthcare professionals so they know how to refer patients.

Step 4: Make a list of all the available referral pathways and display it. See *Annexure 84* as an example.

Step 5: Keep sufficient stock of standardised referral forms. See *Annexure 85* as an example.

Step 6: Complete the patient referral form when a patient is referred. Hand a copy to the patient and keep a copy in the patient record.

Step 7: Keep record of all referred patients in the referral register. See *Annexure 86* as an example.

COMPONENT 10: PARTNERS AND STAKEHOLDERS

31: PARTNERS SUPPORT

Commitment for Ideal Clinic elements 175–176

Implementing partners must support the activities of the facility.

175 There is an up to date list (with contact details) of all implementing health partners that support the facility

176 The list of implementing health partners describes their areas of focus and business activities

Process

Step 1: Obtain a list of implementing partners that are operating in the sub-district/district. The list must include their focus and business activities.

Step 2: Compile a list of implementing partners whose focus and business activities is needed by the facility. The list must be updated when details of the health partners change.

Step 3: The sub-district/district schedules an annual meeting in November with all identified health partners to discuss and agree on their contribution to support the facility in the next financial year.

Step 4: The sub-district/district develops and signs a memorandum of understanding on how the support is going to be carried out.

Step 5: The sub-district/district establishes a reporting framework for all implementing partners to the facility and district. See *Annexure 87* as an example.

Step 6: The quarterly district review meeting could be used for implementing partners to present their support progress.

32: MULTI-SECTORAL COLLABORATION

Commitment for Ideal Clinic elements 177–183

Key Memoranda of Understanding (MoU) will be available at the facility and will be read, understood and applied by the facility manager and staff.

177 There is an official Memorandum of Understanding between the PDoH and SAPS available

178 There is an official Memorandum of Understanding between the PDOH and the Department of Education available

179 There is an official Memorandum of Understanding between the PDOH and Department of Social Development available

180 There is an official Memorandum of Understanding between the NDOH and Home Affairs available

181 There is an official Memorandum of Understanding between the PDOH and Department of Public works available

182 There is an official Memorandum of Understanding between the district management and Cooperative Governance and Traditional Affairs (CoGTA)

183 There is an official Memorandum of Understanding between the PDOH and the Department of Transport

Process

Step 1: Obtain a copy of the relevant MoU from the sub-district/district.

Step 2: Orientate staff to the contents of the MoU.

Step 3: Staff to sign acknowledgment indicating that they are aware of the MoU and its application. See *Annexure 50*.

Step 4: The facility must keep record and provide regular feedback to the sub-district/district on implementation of these MoU including consistent lack of cooperation.

ANNEXURES

ANNEXURE 1:

Components and sub-components of Ideal Clinic dashboard, version 16

ANNEXURE 2:

Ideal Clinic Realisation and Maintenance Dashboard, version 16

NATIONAL CORE STANDARDS	COMPONENT	SUB-COMPONENT		ELEMENTS	WEIGHT	METHOD OF MEASUREMENT	LEVEL OF RESPONSIBILITY	CHECKLIST	PERFORMANCE
DOMAIN 1: PATIENT RIGHTS	1. Administration	**1. Signage and notices:** Monitor whether there is communication about the facility and the services provided							
			1	All way-finding signage in place	I	😐	P	Y	
			2	Display board reflecting the facility name, service hours, physical address, contact details and service package details is visibly displayed at the entrance of the facility	I	😐	D		
			3	The NO WEAPONS, NO SMOKING, NO ANIMALS (except for service animals), NO LITTERING and NO HAWKERS sign is clearly sign posted at the entrance of the facility	I	😐	D		
			4	The vision, mission and values of the district must be visibly displayed	I	😐	D		
			5	The facility organogram with the contact details of the manager is displayed on a central notice board	I	😐	HF		
			6	All service areas within the facility are clearly signposted	I	😐	HF	Y	
		2. Staff identity and dress code: Monitor whether staff uniform, protective clothing and mode of staff identification are according to policy prescripts							
			7	There is a prescribed dress code for all service providers	I	🕮	P		
			8	All staff members comply with prescribed dress code	I	?😐	HF	Y	
			9	All staff members wear an identification tag	I	😐	HF	Y	
		3. Patient service organisation: Monitor the processes that enable responsive patients service							
			10	There is access for people in wheelchairs	E	😐	D	Y	
			11	Staff are scheduled such that helpdesk/reception services are available	I	😐🕮	HF		
			12	There is a process that prioritises the very sick, frail and elderly patients	I	😐	HF		
			13	A functional wheelchair is available	E	?😐	HF		
DOMAIN 6: OPERATIONAL MANAGEMENT	1. Administration	**4. Management of patient record:** Monitor whether patients' record content is organised according to Integrated Clinical Services Management (ICSM) prescripts, whether the prescribed stationary is used and whether the patient records are filed appropriately appropriately							
			14	There is a single patient record (except for active TB patients) irrespective of health conditions	I	😐🕮	HF		
			15	Patient record content adheres to ICSM prescripts	E	😐🕮	HF	Y	
			16	The district/provincial Standard Operating Procedure/guideline for filing, archiving and disposal of patient records is available	I	🕮	P		
			17	The guideline for filing, archiving and disposal of patient records is adhered to	I	😐	HF	Y	
			18	There is a single location for storage of all active patient records	I	😐	HF		
			19	Patient records are filed in close proximity to patient registration desk	I	?😐	HF		
			20	The retrieval of a patient's file takes less than ten minutes	I	?😐	HF		
			21	Priority stationery (clinical and administrative) is available at the facility in sufficient quantities	I	🕮	HF	Y	

NATIONAL CORE STANDARDS	COMPONENT	SUB-COMPONENT		ELEMENTS	WEIGHT	METHOD OF MEASUREMENT	LEVEL OF RESPONSIBILITY	CHECKLIST	PERFORMANCE
DOMAIN 2: PATIENT SAFETY AND CLINICAL GOVERNANCE AND CLINICAL CARE	2. Integrated Clinical Services Management (ICSM)	**5. Clinical service provision:** Monitor whether clinical integration of clinical care services allowing for three discrete streams (acute, chronic and MCWH) of service delivery is adhered to as per service package and whether this results in improvements in key population health and service indicators							
			22	The facility has been reorganised with designated consulting areas and staffing for acute, chronic health conditions and preventative health services	E	😐	HF		
			23	Patients are consulted and examined in privacy	E	😐	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 is <5%	E	🕮	HF		
			26	Antenatal visit rate before 20 weeks gestation is at least 62% or has increased by at least 5% from the previous year	E	🕮	HF		
			27	Antenatal patient initiated on ART rate is at least 95% or has increased by at least 5% from the previous year	E	🕮	HF		
			28	Immunisation coverage under one year (annualised) is at least 92% or has increased by at least 5% from the previous year	E	🕮	HF		
			29	Screening of patients for high blood pressure has increased by 5% since the previous financial year	E	🕮	HF		
			30	Screening of patients for raised blood sugar has increased by 5% since the previous financial year	E	🕮	HF		
			31	At least 35% of patients visiting the clinic are screened for mental disorders	E	🕮	HF		
		6. Management of patient appointments: Monitor whether an ICSM patient appointment system is adhered to							
			32	An ICSM compliant patient appointment system for patients with chronic health conditions and MCWH patient is in use	E	🕮	HF		
			33	The records of booked patients are pre retrieved at least 24 hours before the appointment	E	😐	HF		
			34	Pre-dispensed medication for clinically stable chronic patients is prepared for collection 24 hours prior to collection date/or patients are enrolled on the CCMDD programme	E	?😐	HF		
		7. Coordination of PHC services: Monitor whether there is coordinated planning and execution between PHC facility, School Health Team and WBPHCOT							
			35	Facility renders school health services to schools in its catchment areas	I	🕮	D		
			36	The facility refers patients with chronic but stable health conditions to home- and community-care services (WBPHCOT) for support	E	🕮	HF		
		8. 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							
			37	The ICSM compliant package of clinical guidelines is available in all consulting rooms	E	🕮	D	Y	
			38	80% of professional nurses have been fully trained on ICSM compliant package of clinical guidelines	E	🕮	D		
			39	At least one of the doctors providing services to the clinic have been trained on ICSM compliant package of clinical guidelines	E	🕮	D		
			40	Resuscitation protocol is available	E	🕮	HF		
			41	80% of professional nurses have been trained on Basic Life Support	E	🕮	D		

NATIONAL CORE STANDARDS	COMPONENT	SUB-COMPONENT		ELEMENTS	WEIGHT	METHOD OF MEASUREMENT	LEVEL OF RESPONSIBILITY	CHECKLIST	PERFORMANCE
DOMAIN 2: PATIENT SAFETY AND CLINICAL GOVERNANCE AND CLINICAL CARE	2. Integrated Clinical Services Management (ICSM)		42	All doctors providing services to the clinic have been trained on Basic Life Support	E	🕮	D		
			43	The National Policy for Patient Safety Incident Reporting and Learning is available	E	🕮	NDoH		
			44	The facility's/district's Standard Operating Procedure for Patient Safety Incident Reporting and Learning is available	E	🕮	HF		
			45	The patient safety incident records show compliance to the National Policy for Patient Safety Incident Reporting and Learning	E	🕮	HF	Y	
			46	The National Clinical Audit guideline is available	E	🕮	NDoH		
			47	Clinical audit meetings are conducted quarterly in line with the guidelines	E	🕮	HF		
		9. Infection prevention and control: Monitor whether prescribed infection prevention and control policies and procedures are adhered to							
			48	The National Policy on Infection Prevention and Control is available	E	🕮	NDoH		
			49	There is a staff member who is assigned the infection prevention and control role in a facility	E	🕮	HF		
			50	Staff wear appropriate protective clothing	E	?😐	HF	Y	
			51	The linen in use is clean	I	😐	HF		
			52	The linen is appropriately used for its intended purpose	E	😐	HF		
			53	Waste is properly segregated	E	😐	HF		
			54	Sharps containers are disposed of when they reach the limit mark	V	😐	HF		
			55	Sharps are disposed of in impenetrable, tamperproof containers	V	😐	HF		
			56	Sharps containers are placed on work surface or in wall mounted brackets	E	😐	HF		
		10. Patient waiting time: Monitor whether the facility's prescribed waiting times are adhered to							
			57	The National Policy For The Management Of Waiting Times is available	I	😐	NDoH		
			58	The standard waiting time for every service area is visibly posted	I	😐	HF		
			59	Waiting time is monitored using the prescribed tool	E	🕮	HF		
			60	The average time that patients spend in the facility is not longer than 3 hours	E	🕮	HF		
			61	Patients are intermittently informed of delays and reasons for delays in service provision	I	?	HF		
		11. 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							
			62	The National Patient Experience of Care Guideline is available	E	🕮	NDoH		
			63	The results of the yearly Patient Experience of Care Survey are visibly displayed at reception	E	🕮	HF		
			64	An average overall score of 60% is obtained in the Patient Experience Of Care Survey	E	🕮	HF		
			65	The results obtained from the Patient Experience Of Care Survey are used to improve the quality of service provision	E	🕮	HF		
			66	The National Policy To Manage Complaints/Compliments/Suggestions is available	E	🕮	NDoH		
			67	The facility's/district's Standard Operating Procedure to Manage Complaints/Compliments/Suggestions is available	E	🕮	HF		

NATIONAL CORE STANDARDS	COMPONENT	SUB-COMPONENT		ELEMENTS	WEIGHT	METHOD OF MEASUREMENT	LEVEL OF RESPONSIBILITY	CHECKLIST	PERFORMANCE
DOMAIN 2: PATIENT SAFETY AND CLINICAL GOVERNANCE AND CLINICAL CARE	2. Integrated Clinical Services Management (ICSM)		68	The complaint/compliments/suggestions records show compliance to the National Policy To Manage Complaints/Compliments/Suggestions	E	🕮	HF	Y	
			69	90% of complaints received are resolved	E	🕮	HF		
			70	90% of complaints received are resolved within 25 working days	E	🕮	HF		
			71	Complaints/compliments/suggestions boxes are visibly placed at main entrance/exit	E	😐	HF		
			72	Official complaint/compliment/suggestion forms and pen are available	E	😐	HF		
			73	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	E	😐	HF		
DOMAIN 3: CLINICAL SUPPORT SERVICES	3. Medicines, Supplies and Laboratory Services	**12. Medicines and supplies:** Monitor consistent availability of required good quality medicines and supplies							
			74	There is at least one functional wall mounted room thermometer in the medicine room/dispensary	V	😐	HF		
			75	The temperature of the medicine room/dispensary is recorded daily	V	🕮	HF		
			76	The temperature of the medicine room/dispensary is maintained within the safety range	V	🕮	HF		
			77	There is a thermometer in the medicine refrigerator	V	😐	HF		
			78	The temperature of the medicine refrigerator is recorded twice daily	V	🕮	HF		
			79	The temperature of the medicine refrigerator is maintained within the safety range	V	🕮	HF		
			80	90% of the tracer medicines are available	V	🕮	HF	Y	
			81	Re-ordering stock levels (min/max) is determined for each item on provincial/district formulary	E	😐🕮	HF		
			82	Expired medicine is disposed of according to prescribed procedures	E	?	HF		
			83	Basic surgical supplies (consumables) are available	E	🕮	HF	Y	
		13. Management of laboratory services: Monitor consistent availability and use of laboratory services							
			84	The Primary Health Care Laboratory Handbook is available	E	🕮	NDoH		
			85	Required functional diagnostic equipment and concurrent consumables for point of care testing are available	V	😐	HF	Y	
			86	Required specimen collection materials and stationery are available	E	😐	HF	Y	
			87	Specimens are collected, packaged, stored and prepared for transportation according to the Primary Health Care Laboratory Handbook	E	😐	HF	Y	
			88	The laboratory results are received from the laboratory within the specified turnaround times	E	🕮	HF	Y	
DOMAIN 6: OPERATIONAL MANAGEMENT	4. Human Resources for Health	**14. Staff allocation and use:** Monitor whether the PHC facility has the required HRH capacity and whether staff are appropriately applied.							
			89	Staffing needs have been determined in line with WISN	I	?🕮	D		
			90	Staffing is in line with WISN	I	🕮	D		
			91	A facility with a workload of more than 150 patients per day has a dedicated facility manager whose work content consists of approximately 80% management and 20% clinical work	E	🕮	D		

NATIONAL CORE STANDARDS	COMPONENT	SUB-COMPONENT		ELEMENTS	WEIGHT	METHOD OF MEASUREMENT	LEVEL OF RESPONSIBILITY	CHECKLIST	PERFORMANCE
DOMAIN 6: OPERATIONAL MANAGEMENT	4. Human Resources for Health		92	Work allocation schedule is signed by all staff members	I	🕮	HF		
			93	Leave policy is available	I	🕮	HF		
			94	An annual leave schedule is available	I	🕮	HF		
		15. Professional standards and Performance Management Development System (PMDS): Monitor whether staff are managed according to Department of Public Service Administration (DPSA) prescripts							
			95	There is an individual Performance Management Agreement for each staff member	I	🕮	HF		
			96	Continued staff development needs are determined for the current financial year and submitted to the district manager	I	🕮	HF		
			97	Training records reflect planned training is conducted as per the district training programme	I	🕮	HF		
			98	The disciplinary procedure is available	I	🕮	HF		
			99	The grievance procedure is available	I	🕮	HF		
			100	Staff satisfaction survey is conducted annually	I	🕮	D		
			101	The results of the staff satisfaction survey is used to improve the work environment	I	🕮	HF		
		16. Access to medical, mental health, and allied health practitioners: Monitor patient access to clinical expertise at PHC level							
			102	Patients have access to a medical practitioner	E	🕮	HF		
			103	Patients have access to oral health services	I	?🕮	D		
			104	Patients have access to occupational therapy services	I	?🕮	D		
			105	Patients have access to physiotherapy services	I	?🕮	D		
			106	Patients have access to dietetic services	I	?🕮	D		
			107	Patients have access to social work services	I	?🕮	D		
			108	Patients have access to radiography services	I	?🕮	D		
			109	Patients have access to ophthalmic service	I	?🕮	D		
			110	Patients have access to mental health services	E	?🕮	D		
			111	Patients have access to speech and hearing services	I	?🕮	D		
			112	Patients have access to a pharmacist	I	?🕮	D		
DOMAIN 3: CLINICAL SUPPORT SERVICES	5. Support Services	**17. Finance and supply chain management:** Monitor the consistent availability of a functional supply chain management system as well as the availability of funds required for optimal service provision							
			113	The facility has a supply chain system for general supplies	E	?🕮	HF		
			114	Facility manager uses the supply chain system to ensure adequate replenishment of supplies	E	?🕮	HF		
		18. Hygiene and cleanliness: Monitor whether the required systems and procedures are in place to ensure consistent cleanliness in and around a facility							
			115	Cleaners are appointed in line with WISN guidelines	E	🕮	HF		
			116	All cleaners have been trained on cleaning	E	🕮	HF		
			117	All work completed is signed off by cleaners	E	🕮	HF		

NATIONAL CORE STANDARDS	COMPONENT	SUB-COMPONENT		ELEMENTS	WEIGHT	METHOD OF MEASUREMENT	LEVEL OF RESPONSIBILITY	CHECKLIST	PERFORMANCE
DOMAIN 3: CLINICAL SUPPORT SERVICES	5. Support Services		118	Cleaning materials are available	E	?📖	HF	Y	
			119	Intensive cleaning of a facility is conducted during the least busy times	E	📖😐	HF		
			120	All service areas are clean	E	😐	HF	Y	
			121	Clean running water, toilet paper, liquid hand wash soap and disposable hand paper towels are available	E	😐	HF	Y	
			122	Sanitary and health care waste disposal bins are lined with red plastic bin liners and have functional lids	E	?😐	HF	Y	
			123	General disposal bins are lined with transparent or black plastic bin liners and have functional lids	E	😐	HF	Y	
			124	All toilets are clean, intact and functional	E	?😐	HF	Y	
			125	The exterior of the facility is aesthetically pleasing and clean	E	😐	HF	Y	
			126	Waste is stored in access-controlled rooms	E	😐	HF		
			127	A signed waste removal service level agreement between the health department and the service provider is available	E	📖	P		
			128	Waste is removed in line with the contract	E	?📖	HF		
		19. Security: Monitor whether systems processes, procedures are in place to protect the safety of assets, infrastructure, patients and staff of the PHC facility							
			129	Perimeter fencing is intact	I	😐	HF		
			130	Separate lockable functioning pedestrian entrance/gate	I	😐	HF		
			131	Parking for staff on the facility premises	I	😐	HF		
			132	There is a standard security guard room	I	😐	D	Y	
			133	A signed copy of the service level agreement between the security company and the provincial department of health is available	I	?📖	D		
		20. Disaster preparedness: Monitor whether firefighting equipment is available and whether staff know how to use it and whether disaster drills are conducted							
			134	Functional firefighting equipment is available	E	😐🧯	HF		
			135	The emergency evacuation procedure is practiced annually	E	📖	HF		
			136	Deficiencies identified during the practice of the emergency evacuation drill are addressed	E	📖	HF		
DOMAIN 7: FACILITIES AND INFRASTRUCTURE	6. Infrastructure	**21. Physical space and routine maintenance:** Monitor whether the physical space is adequate for the PHC facility workload and whether timely routine maintenance is undertaken							
			137	Clinic space accommodates all services and staff	E	😐📖	HF		
			138	The facility's infrastructure is maintained	E	😐📖	D		
		22. Essential equipment and furniture: Monitor whether essential equipment and required furniture are available							
			139	Furniture is available and intact in service areas	I	😐	HF		
			140	Essential equipment is available and functional in every consulting room	E	😐	HF		
			141	Resuscitation room is equipped with functional basic equipment for resuscitation	V	😐📖	HF		
			142	Restore the emergency trolley daily or after every time it was used	V	😐📖	HF		
			143	There is a sterile emergency delivery pack	V	😐	HF		

NATIONAL CORE STANDARDS	COMPONENT	SUB-COMPONENT		ELEMENTS	WEIGHT	METHOD OF MEASUREMENT	LEVEL OF RESPONSIBILITY	CHECKLIST	PERFORMANCE
DOMAIN 7: FACILITIES AND INFRASTRUCTURE	6. Infrastructure		144	There is a sterile pack for minor surgery	E	😐	HF	Y	
			145	Oxygen cylinder with pressure gauges available in resuscitation/emergency room	V	😐	HF		
			146	Redundant and non-functional equipment is removed from the facility	I	😐	HF		
		23. Bulk supplies: Monitor whether the required electricity supply, water supply and sewerage services are constantly available							
			147	There is constant supply of clean, running water to the facility	V	?👂	HF		
			148	There is emergency water supply in the facility	E	👂😐	HF		
			149	There is functional back-up electrical supply	E	?😐	HF		
			150	The back-up electrical power supply is checked weekly to determine its functionality	E	🕮	HF		
			151	The sewerage system is functional	E	🕮	HF		
		24. ICT infrastructure and hardware: Monitor whether systems for internal and external electronic communication are available and functioning							
			152	There is a functional telephone in the facility	E	?👂	HF		
			153	There is a functional computer	I	?👂	HF		
			154	There is a functional printer connected to the computer	I	?👂	HF		
			155	There is web access	I	?👂	D		
DOMAIN 4: PUBLIC HEALTH	7. Health Information Management	**25. District Health Information System (DHIS):** Monitor whether there is an appropriate information system that produces information for service planning and decision making							
			156	Facility performance in response to burden of disease of the catchment population is displayed and is known to all clinical staff members	I	?😐	HF		
			157	District Health Information Management System policy available	I	🕮	HF		
			158	Clinical personnel and data capturer trained on the facility level Standard Operating Guidelines for data management	I	🕮	HF		
			159	Relevant DHIS registers are available and are kept up to date	I	?😐	HF		
			160	Facility submitted all monthly data on time to the next level	I	🕮	HF		
			161	There is a functional computerised patient information system	I	?👂	D		
	8. Communication	**26. Internal communication:** Monitor whether the communications system required for improved quality for service delivery is in place							
			162	There are sub-district/district quarterly facility performance review meetings	I	🕮	D		
			163	There is at least a quarterly staff meeting held within the facility	I	🕮	HF		
			164	Staff members demonstrate that incoming policies and notices have been read and are understood by appending their signatures on such policies and notifications	I	🕮	HF		
		27. Community engagement: Monitor whether the community participates in PHC facility activities through representation in a functional clinic committee							
			165	There is a functional clinic committee	I	🕮	P		
			166	Contact details of clinic committee members are visibly displayed	I	😐	HF		
			167	The facility has an annual open day	I	🕮	HF		

NATIONAL CORE STANDARDS	COMPONENT	SUB-COMPONENT		ELEMENTS	WEIGHT	METHOD OF MEASUREMENT	LEVEL OF RESPONSIBILITY	CHECKLIST	PERFORMANCE
DOMAIN 5: LEADERSHIP AND CORPORATE GOVERNANCE	9. District Health System Support			**28. District Health Support (DHS):** Monitor the support provided to the facility through guidance from district management, regular Ideal Clinic status measurement by the PPTICRM as well as through visits from the district support and health programme managers					
			168	There is a health facility operational plan in line with district health plan	I	🕮	HF		
			169	The district Permanent Perfect Team for Ideal Clinic Realisation and Maintenance visits the clinic at least twice a year to record the Ideal Clinic Realisation status and to correct weaknesses	E	?🕮	D		
				29. Emergency patient transport: Monitor the availability of planned and emergency transport for patients					
			170	There is a pre-determined EMS response time to the facility	I	?🕮	D		
			171	EMS respond according to the pre-determined response time	I	🕮	D		
				30. Referral system: Monitor whether patients have access to appropriate levels of health care					
			172	The National Referral Policy is available	I	🕮	NDoH		
			173	The facility's Standard Operating Procedure for referrals is available and sets out clear referral pathways	I	🕮	HF		
			174	There is a referral register that records referred patients	I	🕮	HF		
DOMAIN 5: LEADERSHIP AND CORPORATE GOVERNANCE	10. Implementing Partners and Stakeholders			**31. Implementing partners support:** Monitor the support that is provided by implementing partners					
			175	There is an up to date list (*with contact details*) of all implementing health partners that support the facility	I	🕮	HF		
			176	The list of implementing health partners shows their areas of focus and business activities	I	?🕮	HF		
				32. Multi-sectoral collaboration: Monitor the systems in place to respond to the social determinants of health					
			177	There is an official memorandum of understanding between the PDOH and SAPS	I	🕮	P		
			178	There is an official memorandum of understanding between the PDOH Department of Education	I	🕮	P		
			179	There is an official memorandum of understanding between the PDOH and the Department of Social Development	I	🕮	P		
			180	There is an official memorandum of understanding between the NDOH and Department of Home Affairs	I	🕮	NDoH		
			181	There is an official memorandum of understanding between the PDOH and Department of Public Works	I	🕮	P		
			182	There is an official memorandum of understanding between the district management and Cooperative Governance and Traditional Affairs (CoGTA)	I	🕮	P		
			183	There is an official memorandum of understanding between the PDOH and Department of Transport	I	🕮	P		

SUMMARY OF IDEAL CLINIC WEIGHT CATEGORIES

WEIGHTS	SILVER	GOLD	PLATINUM	DIAMOND
Vital (15 elements)	100%	100%	100%	100%
Essential (87 elements)	70%	80%	91%	100%
Important (81 elements)	65%	76%	87%	100%
AVERAGE	**70-79%**	**80-89%**	**90-99%**	**100%**

Performance is scored in line with three colours as follows:

Green (G) = achieved
Amber (A) = partially achieved
Red (R) = not achieved

Key and description for method of measurement

Key	Method of measurement (MM)
📖	a) Check applicable documents e.g. policies, guidelines, standard operating procedures, data, etc.
?	b) Ask staff members and/or clients for their views or level of understanding
😐	c) Objective observations and/or conclusion
☝	d) Test the functionality of equipment/systems

Key and description for level of responsibility

Key	Description
NDoH	National Department of Health
P	Province
D	District
HF	Health facility

Key and description for weights

Key	Description
V	Vital
E	Essential
I	Important

Definition of weight categories

Vital

Extremely important (vital) elements that require immediate and full correction. These are elements that affect direct service delivery and clinical care to patients and they may have immediate and long-term adverse effects on the health of the population.

Essential

Very necessary (essential) elements that require resolution within a given time period. These are process and structural elements that indirectly affect the quality of clinical care given to patients.

Important

Significant (important) elements that require resolution within a given time period. These are process and structural elements that affect the quality of the environment in which health care is given to patients.

ANNEXURE 3:

Checklist for external signage

Use the checklist below to check the external signage of the facility

Scoring – in column for score mark as follows:

Y (Yes) = if present, **N** (No) = if not present, **NA** (Not applicable) = signage is NA to the specific facility due to the size of the facility (small facilities) or type of services rendered

External signage	Score
Geographical location signage from main roads	
a. Both directions on each main road	
b. At least 1 km from clinic	
c. No obstructions to visibility	
Vehicle entrance signage	
a. Right of admission, subject to search, disclaimer notices	
b. Prohibition symbols – weapons, smoking, animals, hawkers	
Specific external locations	
a. Emergency Assembly point	
Waste storage	
a. Hazardous	
b. Biological	
c. Household/Domestic	
At or near to main entrance of building	
a. Ambulance parking sign	
b. Ambulance parking area marked on paving	
Total score	
Total maximum possible score (sum of all scores minus the ones marked NA)	
Percentage (Total score ÷ Total maximum possible score) x 100	%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
80%	Green
40-79%	Amber
< 40%	Red

ANNEXURE 4:

Checklist for facility's internal signage

Use the checklist below to check whether all service areas within the facility are clearly signposted

Scoring – in column for score mark as follows:

Y (Yes) = if present, **N** (No) = if not present, **NA** (Not applicable) = signage is NA to the specific facility due to the size of the facility (small facilities) or type of services rendered

Internal branding	**Score**
Help Desk/Reception	
Complaints/suggestions/compliments box	
Medicine storage room/ /dispensary/pharmacy (if applicable)	
Emergency room	
Facility Manager – door identifier and name plate	
Emergency exit(s)	
Exit(s)	
Stairs (if applicable)	
Patient toilets	
a. Directional arrows to toilets	
b. Disabled toilet pictogram	
c. Female toilet pictogram	
d. Male toilet pictogram	
Directional signs for service areas – Colour-coded pathway guides (lines/arrows) for each service area	
Consultation rooms for 3 Streams of care or General consultation room (for small facilities): a. Acute/minor ailments (orange) b. Chronic Diseases (blue) c. MCWH (deep green)	
d. Health Support Services (Allied health services) (yellow)	
e. Chronic Medicine Collection (CCMDD)	
f. Medicine storage room/ dispensary/Pharmacy	
Waiting area(s)	
a. No smoking pictogram	
Fire-fighting signs	
a. At each hose, fire hose pictogram	
b. At each extinguisher, fire extinguisher pictogram	

Support/admin areas (room name sign on each door)	
a. Storeroom(s)	
b. Sluice room	
c. Laundry	
d. Kitchen	
e. Patient records storage room	
f. Community Outreach Service	
g. Staff toilet(s)	
h. Staff room/boardroom	
Total score	
Total maximum possible score (sum of all scores minus the ones marked NA)	
Percentage (Total score ÷ Total maximum possible score) x 100	%

NB:
Facilities that are too small (less than three consulting rooms) to be segregated into three streams, will not be expected to have dedicated consulting areas for acute, chronic health conditions and preventative health services with accompanying signage but should still adhere to ICSM principles. This means that patients should be treated holistically and not be sent from one section to another because of co-morbidities. Signage for the three streams should therefore be marked as NA.

Directional signs for streams of services to be on walls or floors to facilitate patient movement.

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
80%	Green
40-79%	Amber
< 40%	Red

ANNEXURE 5:

Dress code and identification tags for staff

Dress code for staff

All staff members

- **An identification tag must be visibly displayed at chest level. The tag shall include the following information:**
  - emblem of the provincial Department of Health
  - full names and surname of the staff member
  - staff designation eg: "professional nurse", "data capturer", "general assistant"
- **General appearance for all staff members**
  - clothing must be clean, neat and fit properly
  - shoes must be clean and in good condition
  - good personal hygiene principles must be adhered to at all times
  - the following is not allowed:
    - clogs, crocs, slip-ons
    - t-shirts
    - jeans, leggings, tights
    - see through clothes
    - low-cut necklines
    - hats
- **General appearance applicable for staff that provide direct patient care**
  - may not wear artificial nails or colored nail polish
  - nails must be short, clean and neatly trimmed
  - hair must be clean and long hair must be tied back
  - minimal jewelry must be worn
  - sleeves must be short (for infection control purposes)

Dress code for nursing staff

Prescribed uniform for females:

- white blouses (no see- through type)
- navy jersey/jacket in the winter season
- navy skirt/slacks
- navy/black court/flat shoes - no clogs, crocs, sandals or slip-ons allowed
- skin colour stockings
- South African Nursing Council (SANC) approved distinguishing devises (epaulettes) must be worn at all times according to the nursing staff's professional qualifications

Prescribed uniform for males:

- white collared shirts
- navy jersey/jacket in the winter season
- navy trousers
- navy blue/black socks
- black shoes – no clogs, crocs, sandals or slip-ons allowed
- SANC approved distinguishing devises (epaulettes) must be worn at all times according to the nursing staff's professional qualifications

Dress code for doctors

Prescribed uniform for females:

- neat blouses (no see- through type)
- neat skirt/slacks
- neat dress with appropriate length (not shorter than 10cm from above the knee)
- jersey/jacket in the winter season
- court/flat shoes – no clogs, crocs, sandals or slip-ons
- optional – white coat worn over clothes

Prescribed uniform for males:

- neat collared shirts
- neat trousers
- jersey/jacket in the winter season
- socks
- closed shoes – no clogs, crocs, sandals or slip-ons
- optional – white coat worn over clothes

Dress code for allied health workers	
Allied groups	Dress colours
Occupational Therapist Radiologist Speech Therapist Physiotherapist Dieticians and Nutritionist	green brown red light blue navy
Prescribed uniform for females: ▸ neat blouses (no see- through type) ▸ skirt/slacks ▸ neat dress with appropriate length (not shorter than 10cm from above the knee) ▸ jersey/jacket in the winter season ▸ court/flat shoes - no clogs, crocs, sandals or slip-ons	**Prescribed uniform for males:** ▸ neat collared shirts ▸ trousers ▸ jersey/jacket in the winter season ▸ socks ▸ black shoes – no clogs, crocs, sandals or slip-ons
Dress code for administration staff, data capturers	
▸ short or long sleeve shirt/blouse ▸ skirt/dresses of appropriate length, smart casual trousers ▸ cardigan, jersey or jacket in the winter season	
Dress code for general assistants, community health workers and lay-councillors	
▸ neat shirt or golf shirt (colours can be determined by district/province) ▸ neat trousers or skirts (colours can be determined by district/province) ▸ jersey or jacket in the winter season ▸ closed shoes and socks – no clogs, crocs, sandals or slip-ons allowed	

ANNEXURE 6:

Checklist for dress code of staff

Use the checklist below to check that the staff on duty are dressed according to prescribed dress code

Scoring – in column for score mark as follows:

Randomly select five staff members to review

Y (Yes) = if present/adhered to, **N** (No) = if not present/not adhered to, **NA** (Not applicable) = if there is not enough staff on duty/appointed to evaluate five staff members, check those on duty

Item	Staff member 1	Staff member 2	Staff member 3	Staff member 4	Staff member 5
Hair neatly tucked					
Nails short					
Jewellery minimal (plain wedding bend, small ear rings, no necklaces)					
Knee length dress/skirts					
No see through clothes					
Tailored clothes (not too tight nor too loose)					
Distinguishing devices					
Score					
Maximum possible score (sum of all scores minus the ones marked NA)					
Total score (sum of scores for 5 staff members)					
Total maximum possible score (sum of maximum possible scores minus the ones marked NA)					
Percentage (Total score ÷ Total maximum possible score) x 100					

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
90%	Green
40-89%	Amber
< 40%	Red

ANNEXURE 7:

Checklist for identification tags

Use the checklist below to check that the staff on duty wear identification tags

Scoring – in column for score mark as follows:

Randomly select five staff members to review

Y (Yes) = if present/adhered to, **N** (No) = if not present/not adhered to, **NA** (Not applicable) = if there is not enough staff on duty/appointed to evaluate five staff members, check those on duty

Staff member	Score
Staff member 1	
Staff member 2	
Staff member 3	
Staff member 4	
Staff member 5	
Total score	
Total maximum possible score (sum of all scores minus the ones marked NA)	
Percentage (Total score ÷ Total maximum possible score) x 100	%

Note:
Identification tag must include the emblem of the facility/district or provincial department of health, full names/initials and surname of the staff member, staff designation.

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
90%	Green
40-89%	Amber
< 40%	Red

ANNEXURE 8:

Checklist for infrastructure accessibility for wheelchairs

Use the checklist below to check the accessibility for users in wheelchairs

Scoring – in column for score mark as follows:

Y (Yes) = if present/adhered to, **N** (No) = if not present/not adhered to

Item	Score
Ramp available at all main entrances to allow access for persons in wheelchairs	
Ramps at all main entrances have handrails	
At least one toilet with access for persons in wheelchairs	
Handrails installed in at least one toilet	
Total score	
Percentage (Total score ÷ 4) x 100	%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 9:

Notice of prioritisation of very sick, frail and elderly patients

PLEASE NOTE

The very sick, frail and elderly patients will be given priority and moved to the front of the queue.

ANNEXURE 10:

Template for training register for staff

By signing against my name in the table below I acknowledge that I have undergone formal training on how to .....

(insert details on specific training, e.g. clean the facility)

Staff name and surname	Persal number	Designation	Signature	Date

ANNEXURE 11:

Checklist for adherence of patient records to ICSM

Use the checklist below to check whether patient records comply with ICSM prescripts

Scoring – in column for score mark as follows:

Randomly select three active records, where possible retrieve a file from each of the three streams of care (Chronic, MCWH and Acute)

Y (Yes) = recorded, **N** (No) = not recorded, **NA** (Not applicable) = if patient did not receive relevant treatment

Type of information/notes	**Score record 1**	**Score record 2**	**Score record 3**
Organisation of patient record – check whether the record is organised into the following sections			
Cover: Administrative detail			
Medical notes			
Laboratory test results			
National stationery (if applicable):			
a. ART (for HIV patient on treatment)			
b. TB (for TB patient on treatment)			
Administrative details (on cover of record)			
Name and surname			
Clinic file number			
Gender			
Contact details			
ID number, if available, or date of birth or passport number			
Patient history (in medical note section)			
Any history of symptoms experienced since last visit			
Patient experiences any symptoms at night that awakes them from their sleep			
Patient visited the general practitioner or other health facilities during the period before the current visit			
Patient asked what and how often they take their medication			
Patient experienced any side-effects on prescribed medication			
Patient asked whether they use any additional medication besides the medication provided by clinic			
Diagnostic condition/s			
Allergies where applicable			
Effect of the condition on the patient's ability to conduct their normal daily living activities			

An enquiry made regarding whether the patient a. smokes cigarettes b. consumes alcohol c. uses snuff			
Examination: Vitals (in medical note section)			
Height of patient at the 1st and 7th visit (if chronic patient)			
Weight at every visit			
Body mass index (BMI) calculated at the 1st and 7th visit (if chronic patient)			
Blood pressure at every visit			
Pulse rate at every visit			
Blood sugar as per guidelines			
Urine dipstick as per guidelines			
Examination: Other (in medical note section)			
Patient fully examined with a view to detecting worsening clinical condition(s)/complications			
a. General (JACCOL)			
b. Chest			
c. Cardiovascular			
d. Abdomen			
e. Mental state examination			
Additional investigation/s conducted as applicable			
a. Foot : at diagnosis and annually in diabetics			
b. Eye : annual ophthalmic examination for diabetics			
Laboratory tests (where applicable, in laboratory test result section)			
Urea and Electrolytes (U&E): annually for diabetes and hypertension			
HBA1C: annually for diabetic patients if stable and after 3 months if treatment is changed			
Cholesterol: at diagnosis			
Cervical smear: as per protocol or if high risk group			
CD4/Viral load : as per clinical guideline			
Patient management (in medical note section)			
Health education provided			
Medication prescribed indicating the following:			
a. Name of medication			
b. Dosage			
c. Route			
d. Frequency			
Referral (where applicable)			
Date of next visit indicated			

Health Care Practitioner's signature			
Date signed by Health Care Practitioner			
Total score (sum of scores for 3 records)			
Total maximum possible score (sum of scores for all 3 records minus the ones marked NA)			
Percentage (Total score ÷ Total maximum possible sore) x 100			

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
90%	Green
40-89%	Amber
< 40%	Red

ANNEXURE 12:

Checklist for filing, archiving and disposal of patient records

Use the checklist below to determine whether the facility adheres to the SOP for filing, archiving and disposal of patient records

Scoring – in column for score mark as follows:

Y (Yes) = adhered to prompt, **N** (No) = not adhered to prompt

Item	Score
Facility/district/provincial SOP for filing, archiving and disposal of patient records are available	
Patient record storage room – patient record storage room adheres to the following:	
Lockable with a security gate	
Shelves to store files	
Lowest shelf start at least 150 mm off the floor, top of shelving is not less than 320 mm from the ceiling to allow airflow	
Aisle and shelves labelled correctly according to SOP	
Counter or sorting table to sort files	
Light is functional	
Is clean, free of dust	
Filing of patient records – the filing system adheres to the following:	
Facility retained patient records in use	
Standardised unique record registration number is assigned to files. Any of the following methods can be used : (surname of patient, Identity Document number or date of birth of patient or a set of numbers)	
Record registration number is clearly displayed on the cover of the patient record	
All patient records are filed as per SOP	
There is a system in place to check that all patient records that were issued for the day are returned at the end of the day	
Annual register available of records that were archived	
Annual register available of records that were disposed	
Total score	
Percentage (Total score ÷ 15) x 100	%

Score calculation: Y = 1 N = 0

Percentage obtained	Score
90%	Green
40-89%	Amber
< 40%	Red

ANNEXURE 13:

Checklist for priority stationery

Use the checklist below to check the availability of stationery

Scoring – in column for score mark as follows:

Y (Yes) = if present, **N** (No) = not present, **NA** (Not applicable) = if stationery is not applicable to the facility

Stationery type	Facilities' minimum quantity	Score
Goods and supplies order forms/books		
Patient record for adults		
Patient record for children		
Active TB patient record		
Road to Health Booklet for Boys		
Road to Health Booklet for Girls		
Appointment Cards - General		
Patient information registers/Tick sheet		
WBPHCOT referral forms		
General referral forms		
Total score		
Maximum possible score (sum of all scores minus the ones marked NA)		
Percentage (Total score ÷ Maximum possible score) x 100		%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
90%	Green
40-89%	Amber
< 40%	Red

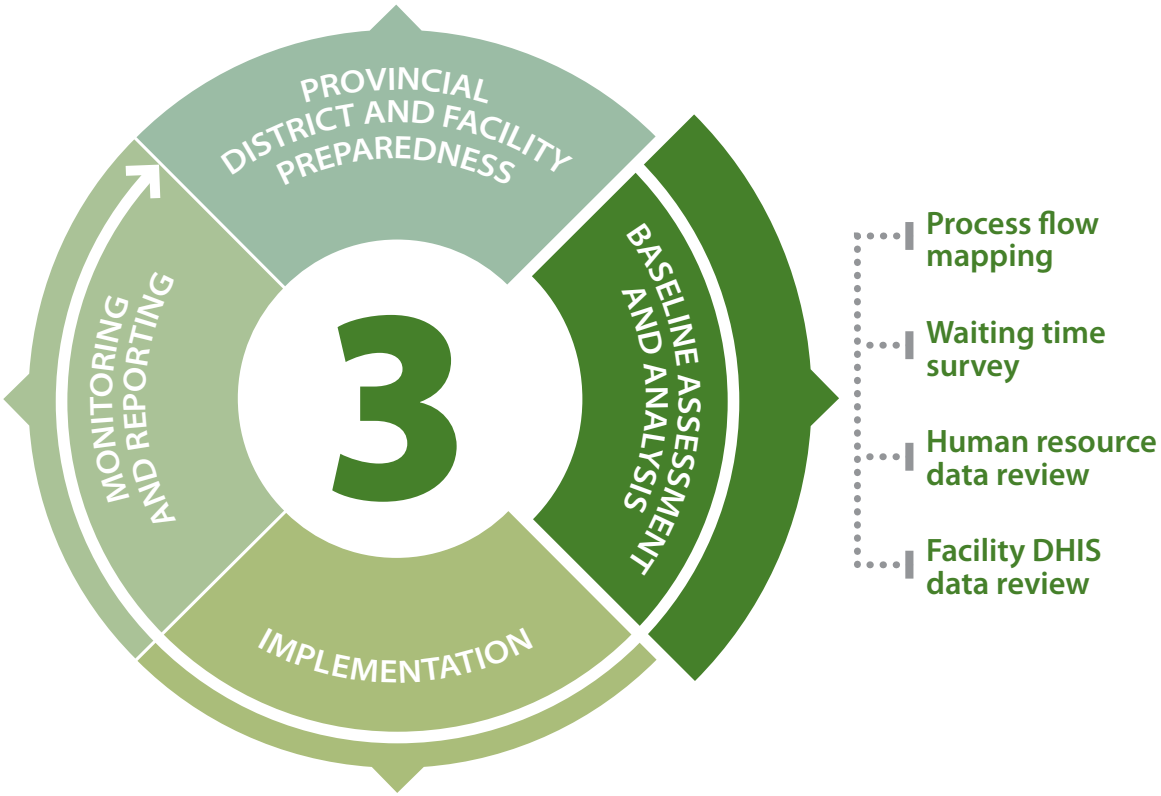
ANNEXURE 14:

Process flow mapping

The baseline assessment represents the first stage of the continuous quality improvement cycle. The purpose of conducting a baseline assessment is:

- to have a snapshot picture of what is happening at the facility
- to identify areas of wastage and inefficacy
- to allow the staff to be involved and to share their experiences.

The findings from the baseline assessment will form the basis for the quality improvement programme design



1. Theoretical framework

In order to provide good quality of clinical care, it is essential that the inputs, processes and outcomes of care conform to desired standards and are continually monitored and improved.

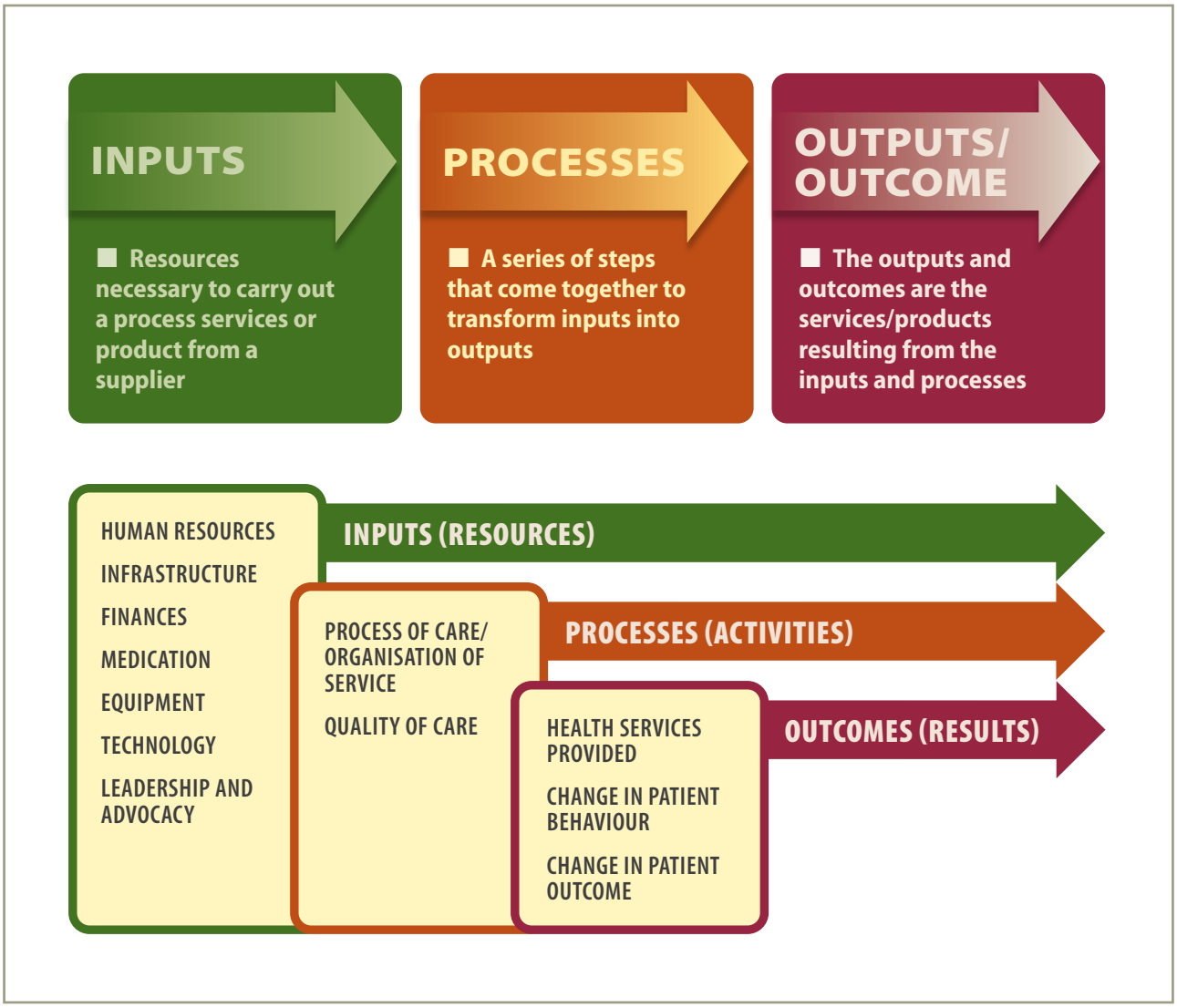


Figure 1: *Modified Systems Framework for Health Service Delivery*

2. The baseline assessment for ICDM involves:

- conducting a waiting time survey or review of previous waiting time survey to determine the base-line for future comparisons
- patient flow analysis – this will be used to identify areas of bottleneck within the healthcare process. Reviewing the last quarter facility health information to determine the number of chronic patients to schedule for daily to achieve an even distribution of patients
- reviewing of human resource data in order to plan the training programme based on the service requirements.

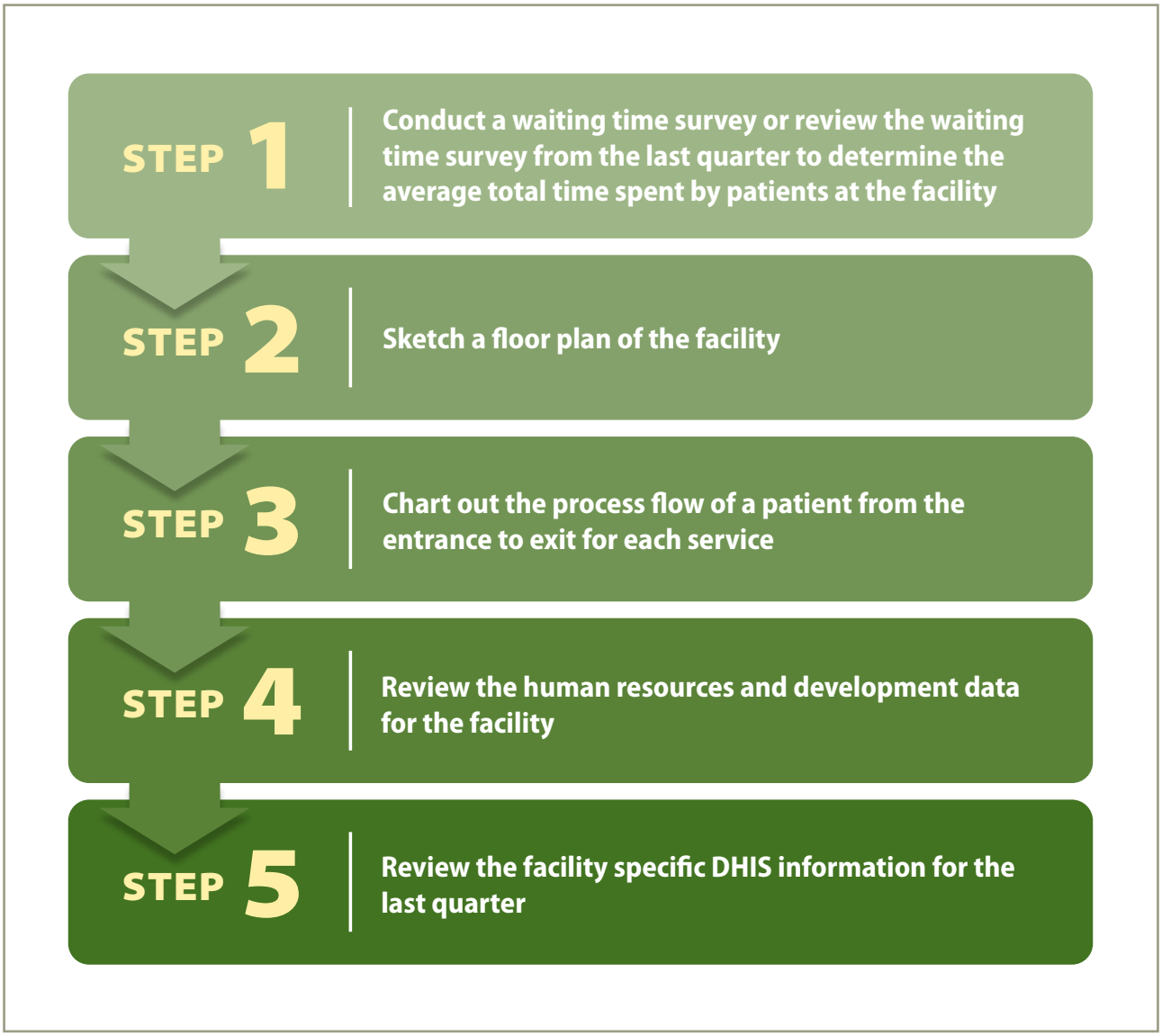


Figure 2: *Activity Steps for Baseline Assessment*

STEP 1:
Conduct a waiting time survey or review the last quarter's waiting time survey results

- **if available**, obtain a copy of the results of the waiting time survey for the last quarter from the appointed facility quality assurance officer
- **if not**, then conduct a waiting time survey as follows:

The waiting time survey consists of two sections:

1. **Facility specific data summary sheet** – to collect data on the availability of staff at the facility on the survey date as well as the total number of patients consulted on that day
2. **Waiting time survey tool** – to collect data on patient waiting times

FACILITY SPECIFIC: DATA SUMMARY SHEET

On the day of the survey

1. The operational manager will complete the facility-specific data summary sheet by indicating the date(s) that the survey was conducted.

2. On the morning of the survey, use the information from the staff attendance register to fill in how many professional nurses are on duty. This is only for primary healthcare and not labour/delivery services (MOU), but must include the nurses doing antenatal care.

3. Indicate the number of enrolled nurses/enrolled nursing assistants on duty.

4. Indicate the number of clerks on duty for the day.

Tool 16

Facility-specific data summary sheet for waiting time survey	
Name of facility	
Date(s) of survey	
Total number of patients seen for the day(s) at the facility	
Total number of professional nurses on duty for the day(s) (outpatient services only)	
Total number of enrolled nursing assistants/ enrolled nurses on duty for the day(s) (outpatient services only)	
Total number of admin clerks/ data capturers on duty for the day(s)	

Waiting time survey methodology

1. All facilities involved in the ICDM project within the district should conduct the survey during the same week with the same start date.

A total of 100 patients should be sampled per facility

FACILITY SPECIFIC: THE SURVEY

The survey

1. The first 100 patients (50 in a small clinic) attending the facility, irrespective of diagnosis, should be surveyed using the waiting time survey tool.

2. **ROW 1:** The queue marshal/enrolled nurse should enter the time that each patient enters the clinic.

3. **ROW 2:** The administrative clerk registering the patient should complete the time after he/she completes the patient registration.

4. **ROW 3:** The enrolled nurse/enrolled nursing assistant at the vital sign station should complete the time after the vital signs have been completed.

5. **ROW 4:** The professional nurse should indicate at what time the patient entered the consulting room.

6. **ROW 5:** The professional nurse should enter time after he/she completes the consultation.

7. The professional nurse should also complete the diagnostic information of the patient.

Condition for which patient is attending	Acute		Chronic				Mother and child		
	IMCI	Minor Ailments	HIV	TB	Non communicable diseases	Mental health	Well-baby/EPI	Family planning	ANC/PNC

8. **ROW 6:** If the patient is referred to another professional nurse or to another service point, for example to receive medication, then the service provider must fill in the time the patient enters the second consultation room.

9. **ROW 7:** When the patient departs the second consultation area, this will be completed.

10. **ROW 8:** The form should be collected by the queue marshal/professional nurse and the time that the patient departs the facility should be indicated.

Tool 17

Waiting time survey tool

	Condition for which patient is attending	Immunisation	ART	Acute minor illness (Adult)	Chronic-NCD	Family planning
		ANC	TB	Well baby clinic	Child health curative	Dressings/ injections
1	Time the patient enters the clinic					
2	Time the patient is registered/ allocated card					
3	Time the patient completed vital signs					
4	Time the patient starts 1st consultation					
5	Time patient completed 1st consultation					
6	Time the patient started 2nd consultation (if referred to another service)					
7	Time the patient completed 2nd consultation (if referred)					
8	Time patient departs clinic					

FACILITY SPECIFIC: AFTER THE SURVEY

After the survey

1. If all 100 patients surveyed are completed in a single day, use the register to provide the total number of outpatients seen for that day and enter this on Tool 16.

2. If the 100 patients surveyed are done on sequential days, then add the total number of patients consulted over the period of days on which the survey was done and also indicate the dates.

3. The data should then be forwarded to the facility Information officer for entry into Microsoft Excel.

STEP 2:
Draw the actual floor plan of the facility in an architectural sketch

- The operational manager and the ICDM champion should sketch the layout of the actual facility

- Each area in the floor plan should be labelled and described in terms of the activity that takes place in that area.

Figure 3: *Example of a Sketched Floor Plan*

STEP 3:
Chart out the process flow

(For a detailed discussion on what a process flow entails and its application, refer to the Quality Improvement Guide developed by the Office of Health Standards Compliance)

a. decide on the beginning and ending points of the process using a patient's perspective
b. there can be more than one starting or ending point
c. identify each step of the process
d. describe the activities of the process
e. correlate each step with the waiting time obtained from the previous survey
f. chart the process in A3 paper (example of process map below)
g. Plot the process as is, even if not ideal
h. Use common symbols such as the ones given below.

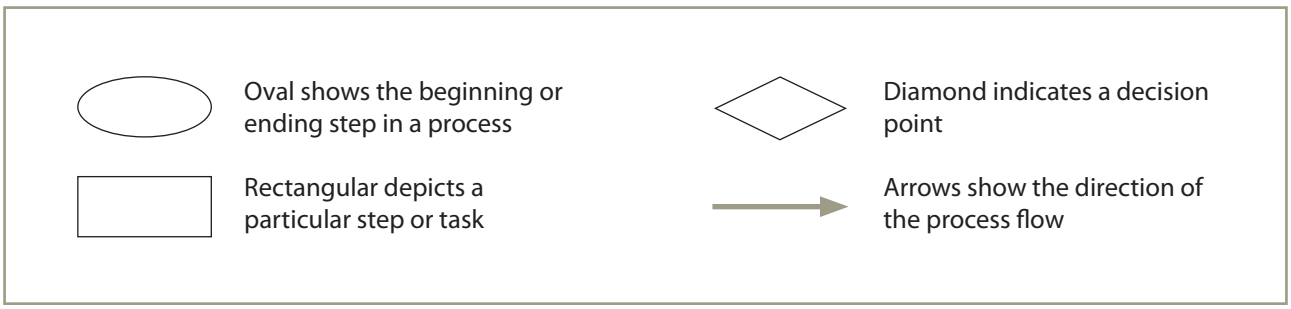


Figure 4: *Flowchart symbols to be used for depicting process flow*

The diagram below is an example of a process flow in a typical clinic:

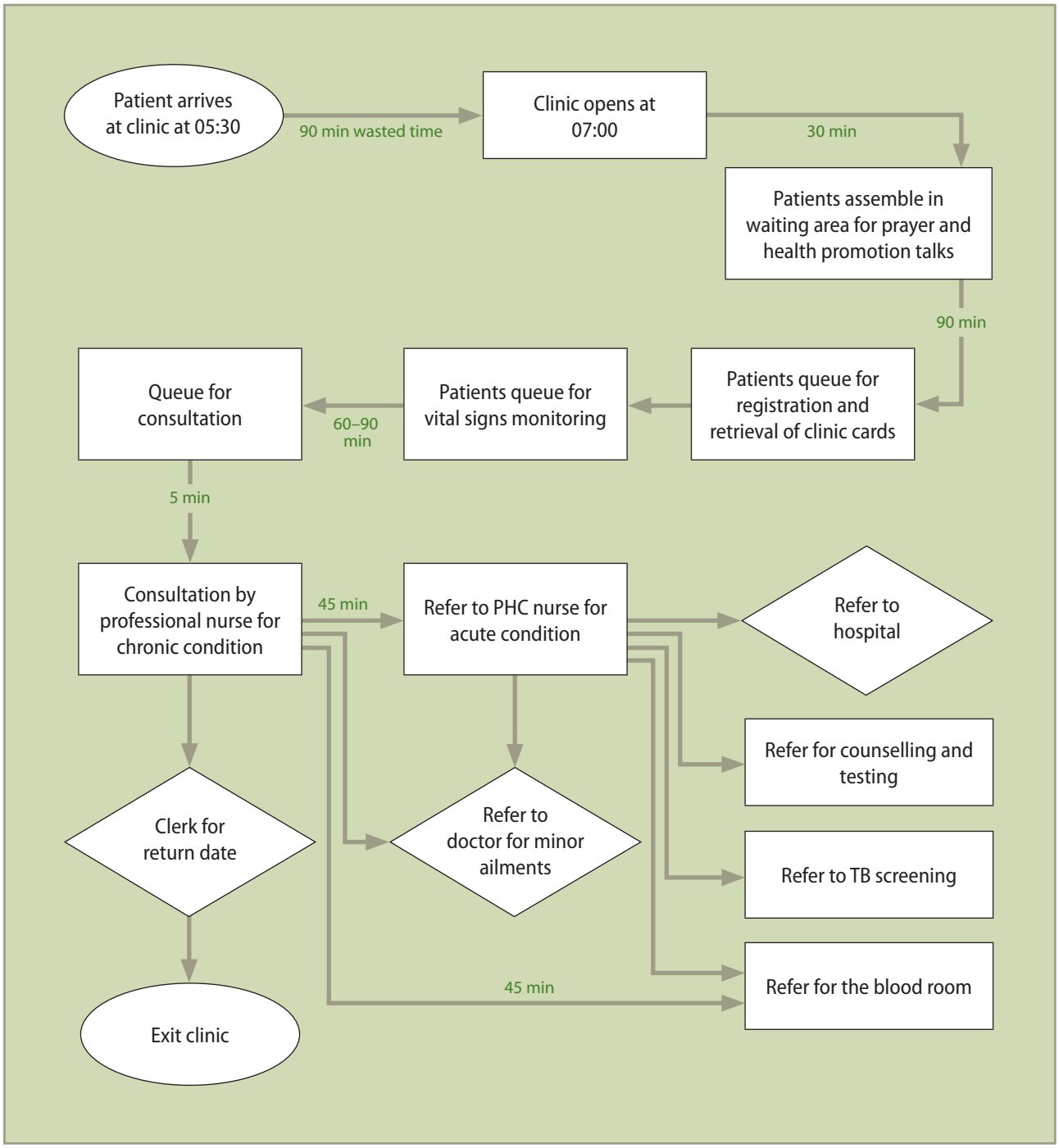


Figure 5: *Example of a process flow plan*

STEP 4:
Review the human resources data

For each professional nurse employed at the facility, obtain the following information and conduct a detailed analysis:

Tool 18

Staff development needs assessment

		Training completed					
Name of professional nurse	South African Nursing Council registration number	Primary Health Care	Palsa plus	Nurse initiated ART (NIMART)	Mental health	Advanced midwifery	PC 101

STEP 5:
Review the facility DHIS information for the last quarter

Tool 19

Summary sheet for DHIS data for the last quarter

Health information for the last quarter	Quarter:
PHC headcount (< 5 years + > 5 years)	
PHC headcount > 5 years	
Number of HIV patients remaining on ART	
Number of patients on pre-ART	
Number of TB patients > 8 years receiving monthly medication	
Number of TB MDR confirmed patients initiated on treatment	
Total number of chronic NCD patients new and follow up (to arrive at this total – sum up the 6 indicators below)	

	Hypertension case load – number of patients with HPT > 5 years visiting the clinic	
	Diabetes case load – number of patients with diabetes > 5 years visiting the clinic	
	Epilepsy case load – number of patients with epilepsy > 5 years visiting the clinic	
	Asthma case load – number of patients with asthma > 5 years visiting the clinic	
	Chronic obstructive airway disease (COPD) case load – number of patients with COPD > 5 years visiting the clinic	
	Mental health case load – number of patients with mental health > 5 years visiting the clinic	

3. Baseline analysis

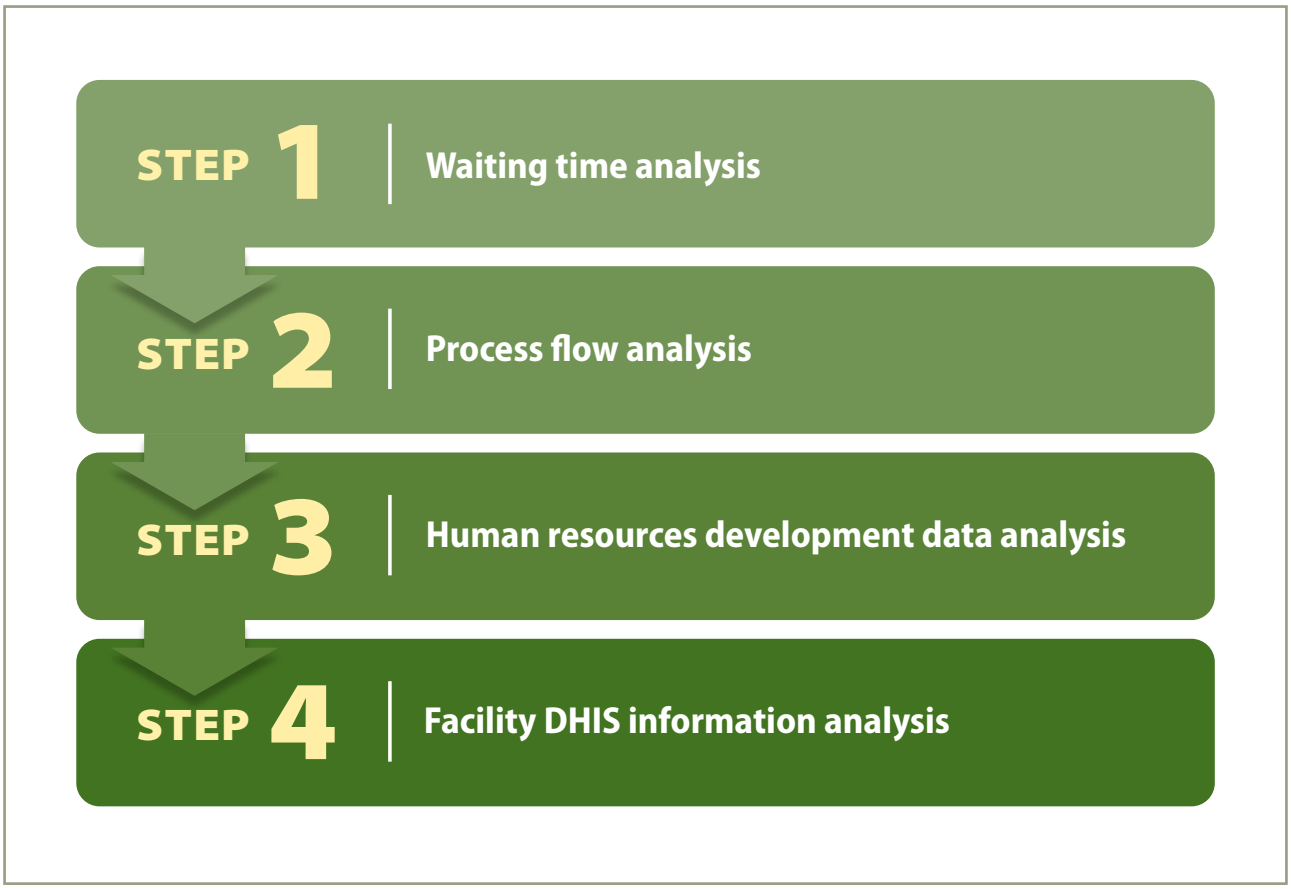


Figure 6: *Baseline analysis activities*

STEP 1:
Waiting time analysis

Assess the following information from the survey:

- nurse to patient ratio – total number of professional nurses on duty on date of survey / total number of patients consulted at facility on the date of the survey
- total median time spent by all patients at the facility

- total median waiting time spent by chronic (HIV and NCD) patients
- total median waiting time between clinic entry and registration
- total median waiting time between registration and vital signs completion
- total median waiting time between vital signs completion and consultation.

This information can be obtained automatically by appropriately inserting the formulas in the Microsoft Excel package and should be in the competence of the facility information officer.

STEP 2:
Process flow analysis

After completing the mapping exercise the team should sit in a meeting room and pin the map on a board. The following question should be answered in analysing the information and for each symptom the question why should be posed to generate possible solutions.

At which point do patients wait the longest and why?

For a detailed discussion on 'process flow' and its application, refer to the Quality Improvement Guide developed by the Office of Health Standards Compliance.

Tool 20

Process flow and waiting time analysis template

Service delivery point	Symptom: Long waiting time
Area A – e.g. between entry and registration	Why? Batching – all patients arriving at a single point together e.g. all patients arrive at the clinic at 06:30 when the clinic opens at 07:00. Over-processing – patients having to go through a process that can be avoided People – availability of the correct type of human resources Equipment – availability of equipment
Between registration and vital signs	
Between vital signs and consultation	
Between consultation and additional service points	
Between consultation and departure from clinic	

STEP 3:
Human resource data analysis

Summarise the human resource data using the table below to identify the number of staff that require further development and the number of staff that can be scheduled to consult chronic patients.

Tool 21

Summary of human resource data	
	Number
Total number of professional nurses employed at the facility	
Total number of enrolled nurses employed at the facility	
Number of professional nurses PHC trained	
Number of professional nurses PALSA Plus trained	
Number of professional nurses NIMART trained	
Number of professional nurses PC 101 trained	
Staff development	
Number of professional nurses that require to be trained	
PHC	
NIMART	
PC 101	

STEP 4:
Analyse the facility specific DHIS information

Tool 22

Analysis of DHIS information for the facility		
Indicators	**Number / %**	**Formula**
Total PHC headcount		
Proportion of patients > 5 years		(PHC headcount > 5 years ÷ total PHC headcount)
Total number of NCD patients		(hypertension case load + diabetes case load + epilepsy case load + asthma case load + chronic obstructive pulmonary disease case load + mental health case load)
HIV patients on ART case load		(number of new patients on ART + total number remaining on ART)
Pre-ART HIV patients		
TB patients > 8 years receiving monthly medication		
Number of TB MDR confirmed patients initiated on treatment		
Total chronic patient case load		(total number of NCD patients + HIV patients on ART case load + pre- ART HIV patients + TB patients > 8 years receiving monthly medication + number of MDR TB patients initiated on treatment)

This information will make it possible for you to develop the ICDM implementation plan.

ANNEXURE 15:

Training register for staff trained on Integrated Clinical Service Management

Module 12	Signature and date												
Module 11	Signature and date												
Module 10	Signature and date												
Module 9	Signature and date												
Module 8	Signature and date												
Module 7	Signature and date												
Module 6	Signature and date												
Module 5	Signature and date												
Module 4	Signature and date												
Module 3	Signature and date												
Module 2	Signature and date												
Module 1	Signature and date												
Designation													
Persal number													
Staff name and surname													

ANNEXURE 16:

Tool to screen patients for mental health disorders

Name and surname of patient .....

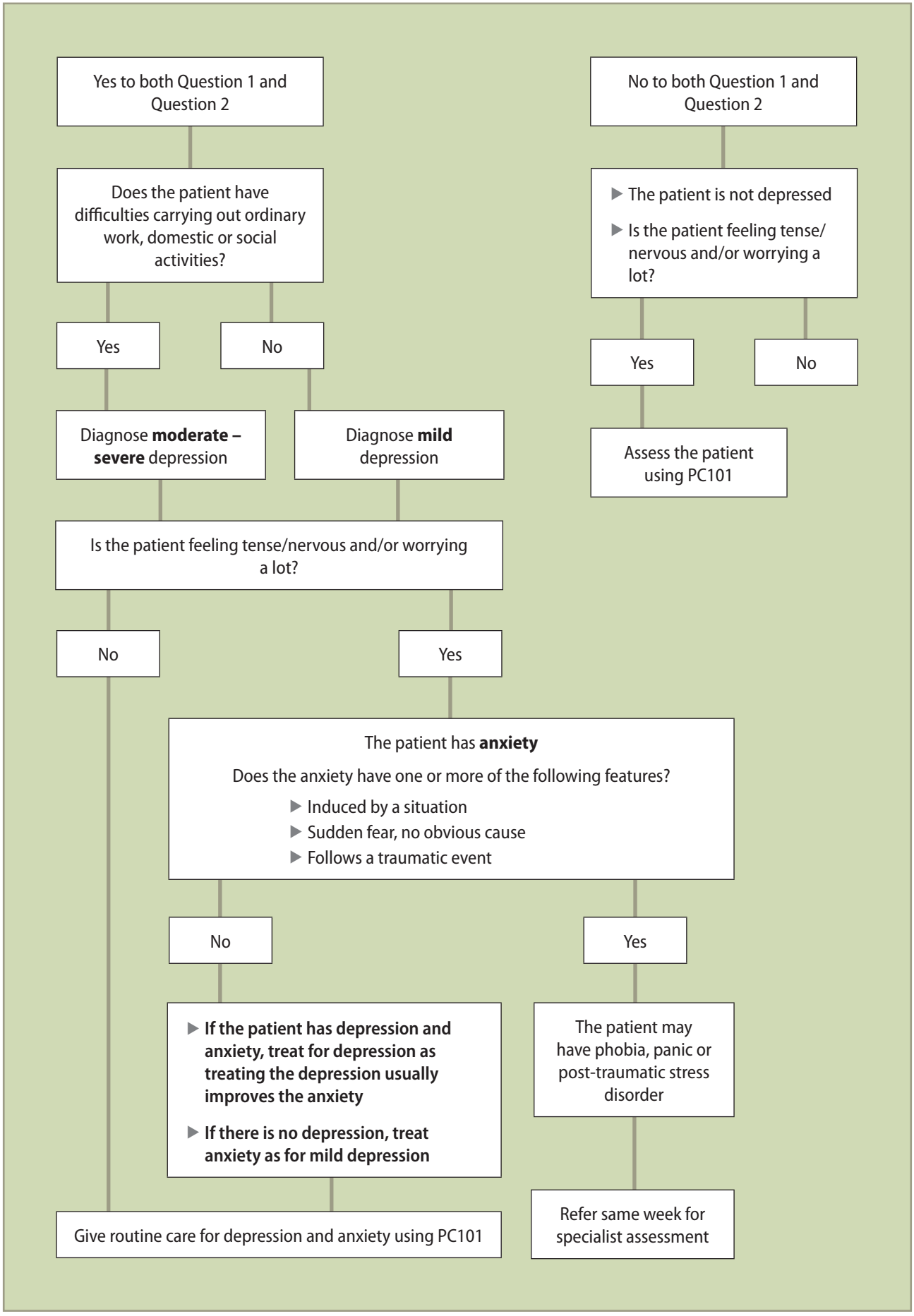
File number .....

I. DEPRESSION AND ANXIETY			
Question 1	**Answer – Mark with a "1" if "Yes"**	**Question 2**	**Answer – Mark with a "1" if "Yes"**
A. Core features of depression – For the past two weeks have you…		B. Other features of depression – For the past two weeks have you…	
1. Felt depressed most of the day almost every day?		1. Experienced reduced concentration and attention?	
2. Lost interest or pleasure in activities those are normally pleasurable?		2. Experienced reduced self esteem and self confidence?	
3. Experienced decreased energy or increased fatigue?		3. Had ideas of guilt and unworthiness?	
		4. Experienced that your view of the future is bleak and negative?	
		5. Experienced ideas or acts of self harm or suicide?	
		6. Sleep been disturbed?	
		7. Your appetite decreased?	
Score section A:		**Score section B:**	
Action if section A scored 2 or more or section B scored 3 or more: follow the guideline to manage anxiety and depression disorders as set out on page 2 (extracted from PC101).			

II. SUBSTANCE ABUSE							
Question 1	**Answer – Mark with a "1" if "Yes"**	**Question 2**	**Answer – Mark with a "1" if "Yes"**	**Question 3**	**Answer – Mark with a "1" if "Yes"**	**Question 4**	**Answer – Mark with a "1" if "Yes"**
1. Has your taking of drugs or alcohol caused serious problems for yourself, family or the community?		1.Did you have more that 5 drinks per session in the last week?		Have you:		1. Have you used any illicit drugs or misused prescription drugs?	
				Ever taken a drink to steady your nerves or treat a hangover?			
		2. If you are a man, do you have more than 21 drinks per week? If you are women do you have more than 14 drinks per week? (1 drink = 1 tot of spirits or 1 small glass of wine or 1 can of beer)		Ever felt that you should cut down on drinking?			
				Felt annoyed if criticised by anyone about your drinking?			
				Ever felt guilty about drinking?			
Score Q 1:		**Score Q 2:**		**Score Q 3:**		**Score Q 4:**	
Action: if score is **1**		**Action:** if score is **1 or more**		**Action:** if score is **2 or more**		**Action:** if score is **1**	
Follow the guideline to manage substance abuse as set out on page 3 (extracted from PC101).							

If during any examination there is any suspicion that the patient may be suffering from psychosis, mania or dementia check symptoms in PC 101 and follow the guideline and refer for diagnosis and management where indicated.

Guidelines to follow for depression and anxiety



Guidelines to follow for substance abuse

Substance abuse: Routine Care	
Assess the patient with substance abuse	
Assess	**Note**
Symptoms	Restlessness, confusion, swearing, sleeplessness, hallucinations, agitation, weakness, tremor, headache, nausea – may be withdrawal.
Harmful use	Alcohol > 35 drinks/ week (man) > 20 drinks/ week (woman) or > 5 drinks/session and or any use of illicit or prescription drugs can become harmful.
Dependence	Much time and energy spent on getting and using substance and withdrawal symptoms above occur on stopping or cutting down.
Trauma/abuse	If patient reports recent trauma or emotional or sexual abuse.
Chronic disease	Chronic use of alcohol and/or drugs can have a long term impact on physical health. Access and manage according to symptoms and chronic disease.
Mental illness	If low mood or sadness, loss of interest or pleasure, feeling tense or anxious or worrying a lot about things, consider depression/anxiety.
Advise the patient with substance abuse	
▸ Educate patient about effects of substance abuse. Explore patient's willingness to cut down or stop. Encourage patient to use helpline. For communicating effectively see preface. ▸ Alcohol: Advise abstinence or moderate use (< 21 drinks/week (man) and avoid binges). Advise the pregnant women to abstain. ▸ Advise patient to stop using illicit or prescription drugs.	
Doctor to treat the dependent patient with substance abuse	
▸ Enrol the dependent patient in a rehabilitation programme starting with detoxification. Ensure patient is motivated to adhere and has the support of a relative/friend. ▸ Admit the patient who refuses help under the Mental Health Act only if there is an accompanying mental disorder and patient is causing harm to self or others. ▸ For inpatient detoxification if previous withdrawal delirium fits, psychosis, suicidal, liver disease, failed prior detoxification, no home support, opioid abuse, or if legally committed or detained. ▸ Doctor to provide outpatient detoxification if none of the above inpatient is abusing alcohol, cannabis, mandrax, cocaine, tik or benzodiazepines.	
Substance	**Detoxification programme**
Alcohol	▸ Thiamine 100mg twice a day for 14 days and ▸ Daizepam orally 10mg immediately; then 5mg 6 hourly for 3 days; then 5mg 12 hourly for 2 days; and then stop. If withdrawal symptoms occur, refer or discuss.
Cannabis / Mandrax / Cocaine / Tik	▸ Treatment not always needed. Review after 1 day of abstinence. ▸ Treat anxiety or sleep problems with diazepam 5mg 1-3 times a day tapering over 3-7 days promethazine 25-50mg orally 8 hourly
Benzodiazepines	▸ Avoid suddenly stopping benzodiazepines after long-term use. ▸ Replace patient's benzodiazepines with diazepam. If on lorazepam 0.5mg-1mg give diazepam 5mg (for other benzodiazepines, refer to SAMF or MIC hotline). ▸ Adjust diazepam according to symptoms, then decrease diazepam by 2.5mg every 2 weeks. On reaching 20% of initial dose taper by 0.5-2mg/week.

ANNEXURE 17:

Appointment scheduling process

Once the start date for consulting patients according to a scheduling system has been determined, the scheduling of patients should commence.

- The scheduling of patients should be done by the professional nurse in the consulting room if a single consultation room is used for consulting chronic patients.
- If more than one consulting room is being used, a number of options could be considered:
    - each professional nurse should be allocated a maximum number of patients that could be booked per day within the respective week and the professional nurse could transcribe them on the scheduling book
    - an administrative clerk could be stationed in a convenient area and schedule the patients according to the information provided by the professional nurse on the chronic patient record.

Determining the appointment date

Depending on the patient's condition and availability of medication at the facility, the patient will either return on:

- a monthly basis if unstable or complicated patient
- every second or third month for a repeat prescription if the patient is clinically stable
- after six months if the patient has been down referred to the PHC outreach team.

Scheduling the appointment

The maximum number of patients that should be consulted daily is pre-determined per facility usage.

- at the beginning of each week, the professional nurses should determine and provide a file day period during which returning patients should be scheduled
- this should be calculated between 25 and 30 days after the current date
- all patients should then be given a choice as to the exact date that they would like to return within this period. The date should not be imposed on the patient
- an appointment file or register needs to be completed using the format described in Tool 14 below
    - patients that are to be initiated on ART should be scheduled for afternoon sessions when NIMART trained or PALSA plus trained nurses will be available to provide them a dedicated service.

Tool 14

Appointment scheduling format – no time slots

Date of appointment

Calendar day

No	Patient file number	Surname and initials of patient	Diagnostic condition	Comments	File retrieved (Y/N)	Patient attended (Y/N)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
Non-scheduled patients						
1						
2						
3						
4						
5						

Date of appointment

This refers to a calendar date. To facilitate the smooth running of the appointment dates you should label all the dates in the forms to cater for operating calendar days for the facility for the year, e.g. 9 April 2012, 10 April 2012.

Number

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, e.g. 32 per day.

Calendar day

Refers to the day of the week - Monday to Friday, and Saturday and Sunday in some instances.

Patient file number

This refers to the patient file number as indicated on the patient record. This will facilitate easy retrieval of the patient record prior to the appointment.

Surname and initials

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 for, e.g. hypertension, diabetes, epilepsy, asthma, COPD, ART.

Comments

This column should contain comments that will assist in triaging the patients as well as monitoring the patient in the process, for example:

- patient defaulted-referred for tracing - you can add address and health tracers name
- doctor appointment
- six month appointment
- repeat prescription and collection of medication
- referred to ophthalmologist/ophthalmic nurse
- referred to social worker.

File retrieved

Pre-appointment retrieval of patient records needs to be done one to three days prior to the appointment. When the administrative clerk retrieves the patient's file, a tick should be made in this column to indicate the file has been retrieved. A cross should be made in red pen if the file is not found and this should be attended to.

ANNEXURE 18:

Pre-dispensing of chronic medication

- Two days prior to the patient's appointment, the patient's clinical records and scheduling list should be provided to the allocated professional nurse for chronic patients or the pharmacist assistant, where available.
- The designated professional should pre-dispense the chronic medicine according to the prescription.
- The medicine 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 as to validate the medicine on issuing to the patient.
- Where plastic bags are not available the facility should adopt innovative measures to pre-dispense the medicine
- Once the medicine has been pre-dispensed, depending on the allocation of the patient, the medicine parcels should then be placed in the medicine cupboard according to alphabetical order in the respective consultation rooms, or kept in the dispensary if it is to be issued by a pharmacist assistant.

ANNEXURE 19:

Tool for acknowledging receipt of chronic medication by patient

Tool for acknowledging receipt of chronic medication by patient					
Name and surname					
Clinic file number					
Identity number or date of birth					
Month in schedule					
Date of 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					

ANNEXURE 20:

School health service referral letter and follow-up assessment form

REFERRAL LETTER TO HEALTHCARE PROVIDER

Basic Education
Health

Date: .....

Dear colleague

Re: Referral for further assessment

During routine health screening it was found that .....

may have a problem with .....

.....

.....

.....

.....

and may require further assessment.

[Add findings in as much detail as possible from school health screening form (e.g., Visual screening left eye 6/18 – Severe visual problem) in the space provided above.]

Kindly complete the attached follow up form indicating the outcomes of the assessment for attention of the school principal.

Yours sincerely

.....
SIGNATURE (School Health Nurse)

.....
PRINT NAME

School Health Stamp

FOLLOW UP ASSESSMENT FORM

Basic Education
Health

Date: .....

Name of clinic: .....

Name of health provider: .....

Designation: (e.g. Prof Nurse) .....

Contact number: .....

Dear Sir / Madam

FOLLOW UP OF HEALTH ASSESSMENT

The following learner ..... was referred for further assessment as a result of the Integrated School Health Screening Programme.

Further assessment conducted Yes / No (tick whatever applicable).

The child must return to the clinic for further treatment on ..... (add date).

Care and support at school level

The school can assist the child in the following ways:
[Add simple interventions e.g. sit at the front of the class for vision problems.]

.....

.....

.....

.....

Please do not hesitate to contact the clinic/private healthcare provider should you require additional information at ..... (add contact numbers)

Yours sincerely

.....
NAME AND SIGNATURE OF HEALTH PROFESSIONAL

School Health Stamp

ANNEXURE 21:

Register of learners referred from school health teams

REGISTER OF LEARNERS ASSESSED WHICH WERE REFREED BY SCHOOL HEALTH

Name of health facility: .....

Month and year: ..... 20 .....

Name and surname of learner	Grade	Name of school	Reason for referral	Referral date	Date learner seen at facility	Date feedback provided to school health teams

ANNEXURE 22:

Referral and back referral form for WBPHCOT

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Referral Form (from outreach team to provider)

A person has been referred to your service by a member of the outreach team working in your ward. Community healthcare workers are mandated by the National Department of Health to identify community members in need of primary health and social services. Thank you for seeing this client, we look forward to working together for improved health and welfare for all South Africans.

Client referred to *(facility name)*	Date referral is made	Ward No

Name of CHW referring client	Outreach team leader name
Contact number for CHW	Team leader contact number

Client details

Client address	Client name and surname		
		Date of birth *(dd/mm/yyyy)*	Age	Gender
Client contact telephone number			

Referred to clinic *(Tick all that apply)*

MCHW	Under 5	Treatment related problems	Other
Antenatal care	Newborn care	TM symptoms	Other health problems (specify below)
Postnatal care	Low birth weight	STI testing	
Pregnancy test	Immunisation	Mental health	
Family planning	Vitamin A	Treatment adherence	
Emergency contraception	Persistent diarrhoea	Chronic health problem	
Cervical contraception	Pneumonia	Chronic health problem	
PCR test for infants	Nutritional/growth problems	HCT	
		CD4 test	
		OIs	

Referred to social services (tick all that apply)		Referred for home-based care (Please write condition that needs home care)
Child-headed household	Protection services	
Food support	Grant support	
Other (specify in box below)	Mental health	
	Support groups	
	Housing	
	Vital documents	

Provide a brief explanation for the referral *(Include place client is being referred if not above and reason for referral)*

Please complete Back-referral Form on the other side of this paper so we can ensure follow-up care. Please contact the outreach team leader noted on this form if you have any further questions regarding this referral.

Signed_____ Date_____

health Department: Health REPUBLIC OF SOUTH AFRICA	**Back-referral Form** **(from provider to outreach team)**
This client was seen by *(provider name)*	Date client seen *(dd/mm/yyyy)*
Facility name	Facility telephone number
Name of referring CHW	Name of team leader
Client details	
Client name and surname	Telephone number
Findings (include diagnosis with patient consent)	
Actions taken (including medicines given/prescribed if relevant)	
Follow-up actions to be monitored or completed by CHW	
Please send client back to this provider on/by_____ for further follow-up *(dd/mm/yyyy)*	
Signature	Date *(dd/mm/yyyy)*

ANNEXURE 23:

Check list for ICSM compliant package of clinical guidelines

Use the checklist below to check the availability of ICSM compliant package of clinical guidelines

Scoring – in column for score mark as follows:

Randomly select two consulting rooms

Y (Yes) = present, **N** (No) = not present, **NA** (Not applicable) = at least one copy of EML for hospitals must be in doctor's room, therefore only one consulting room needs to have one, mark other consulting room as NA

Item	Score Consulting room 1	Score Consulting room 2
Adult Primary Care guide (Primary Care 101) – v2 2013/14 or Practical Approach to Care Kit (PACK) – 2015		
Standard Treatment Guidelines and Essential Medicines List for Primary Health Care – 2014		
Integrated Management of Childhood illness Chart Booklet - 2014		
Standard Treatment Guidelines and Essential Medicines List for Hospital Level, Adults – 2012 (**only in consulting room used by the doctor**)		
Standard Treatment Guidelines and Essential Medicines List for Hospital Level, Paediatrics – 2013 (**only in consulting room used by the doctor**)		
Newborn Care Charts Management of Sick and Small Newborns in Hospital SSN Version 1 – 2014 (**only in consulting room used by the doctor**)		
Score		
Maximum possible score (sum of all scores minus the ones marked NA)		
Total score for all 2 consulting rooms		
Total maximum possible score (sum of all consulting rooms scores minus the ones marked NA)		
Percentage (Total score ÷ Total maximum possible score) x 100		%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 24:

Register for staff trained on Basic Life Support

Record all the staff members' names and surnames in the register. Record the date the first training was conducted. Ensure that follow-up training is conducted every two years.

Keep a copy of the certificate obtained in a file together with the register

Staff name and surname	Persal number	Designation	Date of training	Date of update in 2 years	Date of update in 2 years	Date of update in 2 years
Nursing staff						
Doctors						

ANNEXURE 25:

Patient Safety Incident reporting form

Section A (notification) – to be completed by manager of section where incident took place. Submit section A to next level for notification for SAC 1 incidents

Section B (statement by staff, patient or significant other) – to be completed by staff, patients or significant other that were directly involved while the incident took place

Section C (investigation) – to be completed by investigator(s) of the incident, in most cases this would be the manager(s) of section where the incident took place

SECTION A – Notification

1. Type of Patient Safety Incident (PSI): Mark with an X		
No harm	Near miss	Harmful (adverse event)

Ref no:	

2. Patient information		**3. Staff involved**		
Patient name and surname		Name and surname	Contact detail	Department
Patient file number				
Location (department/ward)				
Age				
Gender				
Final diagnosis				

4. Date of PSI		**5. Time of PSI**	

6. SAC rating: mark with an X	1	2	3	**7. Date reported to next level if SAC = 1**		**8. No of days to report PSI with SAC = 1**	

9. Method of detecting PSI: mark with an X	Reported by health professional	Research studies	Surveys on patient experience of care	Inpatient medical review	Review of record on follow-up	External sources			Safety walk rounds	Focused teams	Use of data
						Public	Media	Complaints			

10. Short description of Patient Safety Incident (detailed information available under section B as reported by staff)			
11. Immediate resulting action taken to minimise harm			
12. Short description of initial disclosure			
Compiled by:	**Designation:**	**Signature:**	**Date:**

SECTION B – Statement by staff, patient or significant other

1. Statement by staff, patient or significant other: (Add sections for additional statements and information as needed)			
Statement 1:			
Compiled by:	**Designation:**	**Signature:**	**Date:**

SECTION C – Investigation

1. Category according to type – mark appropriate one with an X					
1. Clinical Administration	**2. Clinical process/ procedure**	**3. Healthcare associated infections**	**4. Medication / IV fluids**	**5. Blood and blood products**	**6. Medical device**
Medical procedure performed without valid consent	Not performed when indicated	Bloodstream	Wrong dispensing	Adverse reaction	Lack of availability
7. Behaviour	Performed on wrong patient	Surgical site	Omitted medicine dose	Wrong blood/ blood product	Failure / malfunction
Intended self harm/ suicide	Wrong process/ procedure/ treatment performed	Pneumonia	Medicine not available	Wrong dose or frequency	**10. Resources/ organisational**
Attempted suicide	Retention of foreign object	Urinary drain/tube	Adverse drug reaction	**9. Infrastructure/buildings/ fixtures**	Bed/service availability/ adequacy
Sexual assault by staff member	Pressure sores acquired during admission	Communicable diseases	Wrong medicine	Damaged/ faulty/ warn	Human resources/staff availability/ adequacy
Sexual assault by fellow patient or visitor	Performed on wrong body part/ site/side	**8. Patient accidents**	Wrong patient	Non-existent/ inadequate	Protocols/policy/procedure/ guideline available/ adequate
Physical assault by staff member	Maternal death	Falls	Wrong frequency		**11. Other**
Physical assault by fellow patient or visitor	Neonatal death		Wrong route		Any other incident that does not fit into categories 1 to 10
Wandering/abscond	Fresh still born		Prescription error		
			Wrong dose/ strength administered		

2. Framework for Root Cause Analysis and implementation of action plans							
a. Contributing factors – Mark with an X							
1. Staff	Cognitive	Performance	Behaviour	Communication	Patho-Physiological/ Disease		
2. Patient	Cognitive	Performance	Behaviour	Communication	Patho-Physiological/ Disease	Emotional	Social
3. Work/environment	Physical environmental / infrastructure		Remote/ long distance from service		Environmental risk assessment/safety evaluation	Current code/specifications/ regulations	
4. Organisational/service	Protocols/policies/procedures		Processes		Organisational decisions/culture	Organisation of teams	
5. External	Natural environment				Products, technology and infrastructure		
6. Other							

b. Root Cause Analysis				
Contributing factor	Describe the factor that contributed to the event	Describe the action plan to rectify the identified problem	Person responsible for implementing the action plan	Date for implementation

3. Findings and recommendations by Patient Safety Committee

4. Conclusion					
Type of behaviour according to Just Culture: mark with a X	Human Error		At – Risk Behaviour		Reckless Behaviour
Patient outcome: mark with a X	None	Mild	Moderate	Severe	Death

5. Summary of final disclosure to patient/family							
6. Date of closure of PSI case		**7. No days to close PSI case**		**8. Type of closure: mark with an X**	PSI case concluded	Litigation	Referred to labour relations
9. Patient outcome according to degree of harm: Mark with an X			None	Mild	Moderate	Severe	Death
10. Organisational outcome: Mark with an X	Property damage	Increase in required resource allocation for patient	Media attention	Formal complaint	Damaged reputation	Legal ramifications	Other
Compiled by:		**Designation:**		**Signature:**		**Date:**	

ANNEXURE 26:

Patient Safety Incident (PSI) register

Annexure A from national policy to manage PSI: Patient Safety Incident (PSI) register

Health establishment name ..... **Month/year** .....

Ref No.	Date and time of incident	Patient's name and surname	Type of PSI	SAC score	Reporting date of SAC 1 incidents	# of working days to report SAC 1 incident	Summary of incident	Finding (all incidents) and recommendations by Patient Safety Committee (for SAC 1 incident)	Class according to incident type	Class according to agent	Patient outcome	Organisational outcome	Date PSI closed	Type of closure	Type of behaviour	# of working days to close PSI

ANNEXURE 27:

Records for statistical data on Patient Safety Incidents (PSI)

Statistical data on classification for agents (contributing factor)

Establishment name/province: **Financial year:**

(Q = Quarter)

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
Agent	**Apr**	**May**	**Jun**	**Q1**	**Jul**	**Aug**	**Sept**	**Q2**	**Oct**	**Nov**	**Dec**	**Q3**	**Jan**	**Feb**	**March**	**Q4**	**TOTAL**	**AVG**	**%***
1.Staff factors																			
Cognitive factors																			
Performance																			
Behaviour																			
Communication factors																			
Patho-physiologic/ disease related factors																			
Emotional factors																			
Social factors																			
2. Patient factors																			
Cognitive factors																			
Performance																			
Behaviour																			
Communication factors																			
Patho- physiologic/ disease related factors																			
Emotional factors																			
Social factors																			
3. Work/environment factors																			
Physical environment/ infrastructure																			
Remote/long distance from service																			
Environmental risk assessment/safety evaluation																			
Current code/ specifications/regulations																			
4.Organisational/service factors																			
Protocols/policies/ procedures																			
Processes																			
Organisational decisions/ culture																			
Organisation of teams																			

5. External factors																			
Natural environment																			
Products, technology and infrastructure																			
Services, systems and policies																			
11. Other																			
Other																			
Grand Total																			

** (Total of agent in Column Q ÷ Grand Total of Column Q) x 100*

Statistical data on classification according to type of Incident

Establishment name/province: **Financial year:**

(Q = Quarter)

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
Type	**Apr**	**May**	**Jun**	**Q1**	**Jul**	**Aug**	**Sept**	**Q2**	**Oct**	**Nov**	**Dec**	**Q3**	**Jan**	**Feb**	**March**	**Q4**	**TOTAL**	**AVG**	**%***
1. Clinical administration																			
Medical procedure performed without consent																			
2. Clinical process/procedure																			
Not performed when indicated																			
Performed on wrong patient																			
Wrong process/procedure/ treatment performed																			
Performed on wrong body part/ site/side																			
Retention of foreign object during surgery																			
Pressure sores acquired during admission																			
Maternal death																			
Neonatal death																			
Fresh stillborn																			
3. Healthcare associated infections																			
Bloodstream																			
Surgical site																			
Pneumonia																			
Urinary drain/tube																			
Communicable diseases																			
4. Medication/IV Fluids																			
Wrong dispensing																			
Omitted medicine or dose																			

Medicine not available																			
Adverse drug reaction																			
Wrong medicine																			
Wrong dose/strength administered																			
Wrong patient																			
Wrong frequency																			
Wrong route																			
Prescription error																			
5. Blood or blood products																			
Adverse transfusion reactions																			
Delayed transfusion reactions/ events (including transfusion transmitted infections)																			
Errors – wrong blood/ blood products																			
6. Medical devices/equipment/property																			
Lack of availability																			
Failure/malfunction																			
7. Behaviour																			
Intended self harm/suicide																			
Attempted suicide																			
Sexual assault by staff																			
Sexual assault by fellow patient or visitor																			
Physical assault by staff																			
Physical assault by fellow patient or visitor																			
Wandering/absconding																			
8. Patient accidents																			
Falls																			
9. Infrastructure/buildings/fixtures																			
Damaged/ faulty/ worn																			
Non-existent/inadequate																			
10. Resources/organisational																			
Bed/service availability/ adequacy																			
Human resource/staff availability/adequacy																			
Protocols/policy/ procedure/guideline availability/adequacy																			
11. Other																			
Any other incident that does not fit into category 1 to 10																			
Grand Total																			

** (Total of type in Column Q ÷ Grand Total of Column Q) x 100*

Statistical data on classification according to incident outcome

Patient Outcome																			
Establishment name/province:												**Financial year:**							
																			(Q = Quarter)
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
Outcome	**Apr**	**May**	**Jun**	**Q1**	**Jul**	**Aug**	**Sept**	**Q2**	**Oct**	**Nov**	**Dec**	**Q3**	**Jan**	**Feb**	**March**	**Q4**	**TOTAL**	**AVG**	**%***
None																			
Mild																			
Moderate																			
Severe																			
Death																			
Grand Total																			

** (Total of outcome in Column Q ÷ Grand Total of Column Q) x 100*

Organisational Outcome																			
Establishment name/province:												**Financial year:**							
																			(Q = Quarter)
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
Outcome	**Apr**	**May**	**Jun**	**Q1**	**Jul**	**Aug**	**Sept**	**Q2**	**Oct**	**Nov**	**Dec**	**Q3**	**Jan**	**Feb**	**March**	**Q4**	**TOTAL**	**AVG**	**%***
Property damage																			
Increase in required resource allocation for patient																			
Media attention																			
Formal complaint																			
Damaged reputation																			
Legal ramifications																			
Other																			
Grand Total																			

** (Total of outcome in Column Q ÷ Grand Total of Column Q) x 100*

Statistical data on indicators for Patient Safety Incidents (PSI)

Name of establishment/province: ..... **Financial year:** .....

Column name	A	B	C	D	E	F	G	H
Month	# PSI cases	#PSI cases closed	% PSI cases closed – (Column B ÷ Column A) x 100	# PSI cases closed within 60 working days	% of PSI cases closed within 60 working days – (Column D ÷ Column B) x 100	# PSI SAC 1	# SAC 1 incidents reported within 24 hours	%of SAC 1 incidents reported within 24 hours – (Column F ÷ Column G) x 100
April								
May								
June								
Quarter 1								
July								
Aug								
Sept								
Quarter 2								
Oct								
Nov								
Dec								
Quarter 3								
Jan								
Feb								
March								
Quarter 4								
TOTAL								
AVERAGE								

ANNEXURE 28:

Checklist for Patient Safety Incident (PSI) record

Use the checklist below to check the availability of records required for the effective management of Patient Safety Incidents

Scoring – in column for score mark as follows:

Check patient safety records for the past three months. ***Note:*** *in cases where no incidents occurred in the past three months the records should still be completed indicating a '0' on statistical forms for the particular months. Register must also be present indicating in first line of register 'No incidents reported'*

Y (Yes) = available, **N** (No) = not available

Item	Score
Patient Safety Incident Register	
Statistical data on classifications of agents involved	
Statistical data on classifications of incident type	
Statistical data on classifications of incident outcome	
Indicators for patient safety incidents	
Total score	
Percentage (Total score ÷ 5) x 100	%

Score calculation: Y = 1 N = 0

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 29:

Checklist for personal protective clothing

Use the checklist below to check whether protective clothing is available and worn

Scoring – in column for score mark as follows:

Y (Yes) = available/worn, **N** (No) = not available/not worn, **NA** (Not applicable) = if staff are not in a situation where they need to wear protective clothing at the time of the audit

Item	Score – stock available	Score – worn by staff
Gloves – non sterile		
Gloves – sterile		
Long sleeve/disposable gowns		
Protective face shields		
Score		
Maximum possible score (sum of all scores minus the ones marked NA)		
Total score for all stock available and worn by staff		
Total maximum possible score (sum of all stock available and worn by staff minus the ones marked NA)		
Percentage (Total score ÷ Total maximum possible score) x 100		%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 30:

Guideline for linen management

Patients' linen

Clean linen is the linen that has been properly laundered and rendered safe for specified patient use. Cotton drapes that have been sterilised by the Central Sterile Services Department (CSSD) after they have been laundered are also regarded as clean linen.

Basic principles of management of linen

Since these types of linen are free from contamination, they should also be prevented from becoming contaminated before being used on patients. It should also be ensured that the clean linen is stored alone in a room that is designated for clean line only. Clean linen must:

- be transported from the laundry to the user area in clean, closed containers.
- be stored on shelves in a designated clean area (linen room dedicated for clean linen only) or cupboard that is kept closed at all times
- trolleys that are solely designated for transporting clean linen must be used
- be stacked on a linen trolley during bed making times and also on the trolley that is parked outside the patient room
- not be left on the trolleys when bed making is done since it will become contaminated
- never be placed on the floor
- there must never be any contact between clean and soiled linen at any time
- sluicing of soiled linen should be done at laundry rather in the sluice room of the ward/clinic
- dirty linen must be stored in closed bags in a designated area (dirty linen room) for a period not exceeding twenty four hours until it is collected from the unit/ward /clinic /operating theatre to the laundry through the exit leading to the outside of the room and never be transported within the ward
- the storage period of dirty linen must not exceed 24 hours
- the door of the dirty linen room must be kept closed and access to the room must be restricted. Dirty linen must be collected from and transported to the laundry in properly colour coded laundry bags.
- the reusable laundry bags, linen trolleys, vehicle and any spillage with appropriate disinfectants must be appropriately washed before being returned to the wards or linen rooms.

Hands must always be cleaned before handling clean linen. Since dirty linen is always heavily contaminated with a wide variety of micro-organisms, it should always be handled with care to prevent cross contamination. The movement of clean and dirty linen from the point of use to the processing area and back is shown in the figure 1 below. Green coloured circles depict clean linen while the red coloured circle depicts dirty linen.

Standard operating procedure for handling dirty linen

- wear gloves and plastic apron when handling soiled, infectious or infested linen and gloves. NB - There is no need to wear gloves when handling used, dry linen
- move canvass trolley for dirty linen to the foot end of the patient bed, examination table or operating table

- with a gloved hand, remove foreign objects such as dressings, sticky tape, instruments, sharps or food stuff on the linen and dispose them separate from the linen – human excreta and any other discharges may not be removed from the linen while in the ward or service area but are rather sent to the laundry in a separate properly labeled plastic bag e.g. 'Sluice'
- do not shake dirty linen
- roll the linen inside out towards the foot end of the bed, bundle and place into the appropriate coloured canvass bag while ensuring that it does not come into contact with your clothing
- transfer the linen directly from there into the canvass bag on the trolley. Do not carry dirty linen to the dirty linen room or place it on other surface as it will contaminate the protective clothing or the surfaces onto which it is placed
- close the bag when it is three quarter full then wheel it to the temporary storage room. Infectious linen is closed immediately and wheeled to the temporary storage room
- label the canvass bag containing the linen with the date and the ward, unit or clinic name
- in case where the linen is infested place it in a plastic bag, place additional label i.e. 'infested linen' or 'pest control' and immediately call the pest control department to treat the linen before sending it to the laundry
- wash or spray hands with a disinfectant after handling dirty linen including when moving from one patient's bed to another when making beds.

Note: Bed linen and towels must be changed daily and immediately respectively irrespective of having no visible soiling or contamination.

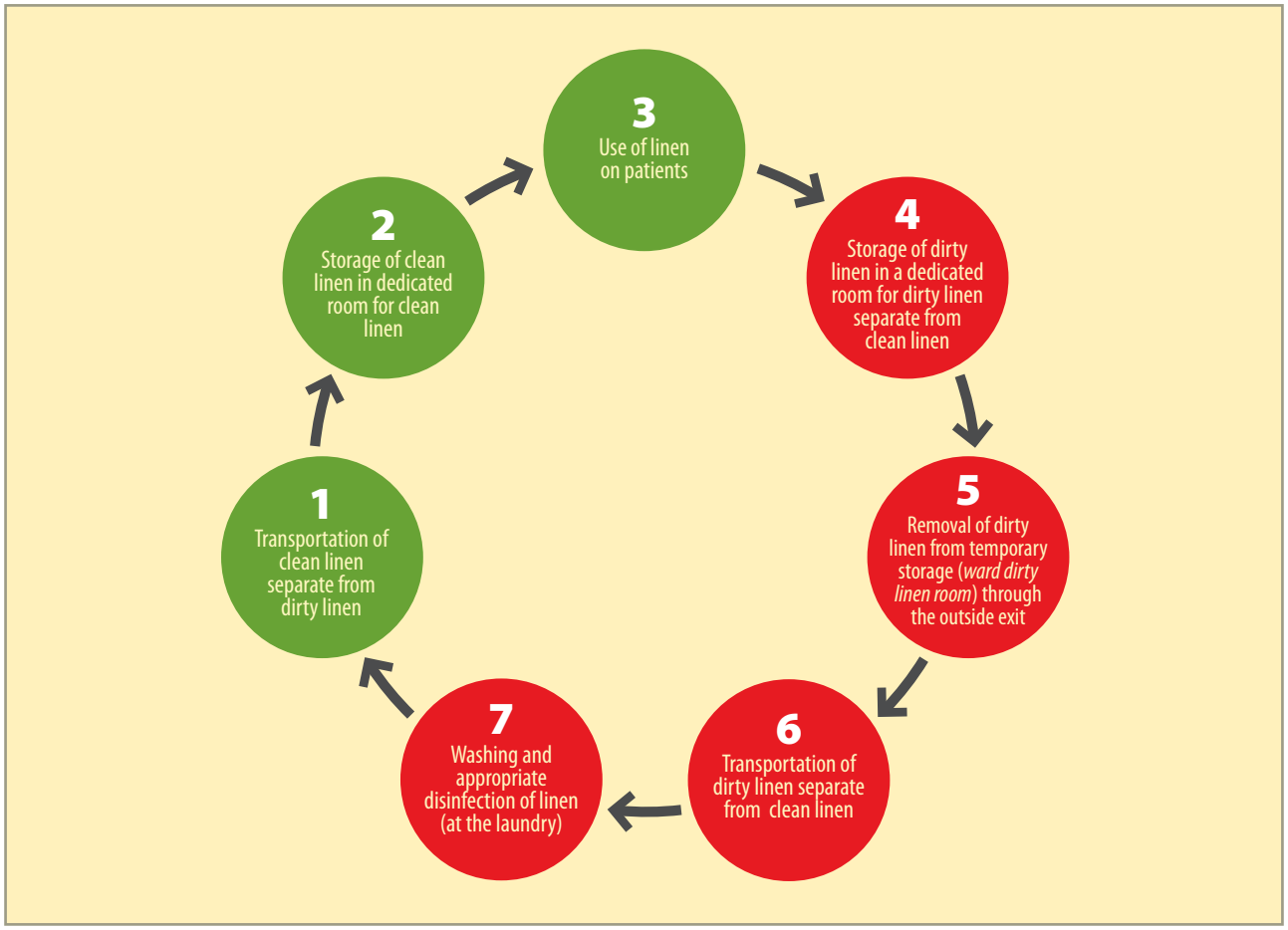


Figure 1: *Linen process*

ANNEXURE 31:

Waste segregation and colour coding

A universal colour-coding system has been developed which emphasises linkage of colour to the type and risk of the waste contained or is expected to contain. There should be clearly visible charts showing what goes into which colour bag or container. If a container and a plastic bag are used then both must be of the same colour.

Colour coding of waste containers

Category	Examples	Colour	Destination
Category A	Paper, cardboard, yard clippings, wood or similar materials, fruit and food containers. Office papers, wrapping papers.	Black/transparent	Recycling
	Leftover food from patients and kitchen and this includes peels from vegetables and fruits. It excludes all containers thereof.	White	Compost/animal feed
Category B	Discarded syringes, needles, cartridges, broken vials, blades, rigid guide wires, trochars, cannulae.	Yellow, shatterproof, penetration and leakage resistant	Incineration
Category C	Human tissues, placentas, human organs/limbs, excision products, used wound dressings, used catheters and tubing, intravenous infusions bags, abdominal swabs, gloves, masks, linen savers, disposable caps, theatre cover shoes and disposable gowns. Sanitary towels, disposable baby napkins.	Red, leakage resistant	Incineration
Category D	Empty aerosol cans, heavy metal waste and discarded chemical disinfectants.	Shatterproof, penetration and leakage resistant des ignated with a "Flammable" sign	Incineration and landfill
Category E	Contaminated radio-nuclide's whose ionizing radiation have genotoxic effects. Also pharmaceutical products, chemical waste, cytotoxics waste materials.	High lead density material	Radio-active waste storage – hot-laboratory – lab pots then landfill.

With the use of the correct plastic bag colour, each container is automatically labeled as clinical waste, non-clinical waste, kitchen waste, etc. When the bag is three quarters full, each bag or container must be labeled with the name of the ward/service area, and be dated then be closed and secured and indicate the name of the person that closed it. Each new container or sharps container should be labeled when replaced.

ANNEXURE 32:

Waiting time survey and calculation tool

Note down the information as indicated in the table below to record waiting time, see page for further explanation

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

Acute		Chronic				Mother and Child		
IMCI	Minor Ailments	HIV	TB	NCD	Mental health	Well-baby/ EPI	Family planning	ANC /PNC
24 hour Emergency Unit	24 hour MOU							

No	Area	Note down the time the patient arrives and leaves
1	Time the patient enters clinic	
2	Time the patient is registered/allocated card	
3	Time the patient completed vital signs	
4	Time the patient starts 1st consultation	
5	Time the patient completed 1st consultation	
6	Time the patient started 2nd consultation (if referred to another service)	
7	Time the patient completed 2nd consultation (if referred)	
8	Time the patient started 3rd consultation (if referred to another service)	
9	Time the patient completed 3rd consultation (if referred)	
10	Time the patient arrived at the Pharmacy	
11	Time the patient is assisted at the Pharmacy	
12	Time the patient departs clinic (the last point of contact with service provision)	

Name of Facility: .....

Date: .....

Number of patients surveyed: .....

Calculated fields

Instruction to complete the waiting time calculation tool:

In column B select from the dropdown list the diagnostic information of the patient, it is compulsory to select an item from the dropdown list to ensure that all values are calculated correctly

Capture the times as captured on the waiting time survey tool. Note the format must be 08:00

SUMMARY OF TIME	Time spent in facility	Waiting time spent in facility	Consultation time spent in facility	Waiting time for registration	Waiting time at Pharmacy	Waiting time spent in ACUTE stream in facility	Waiting time spent in CHRONIC stream in facility	Waiting time spent in MOTHER &CHILD stream in facility
Total time	89:45	59:48	08:56	11:10	03:29	07:45	22:39	05:45
Average time	22:26	14:57	02:14	02:47	00:41	02:35	03:14	02:52

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
Pt No	Diagnostic information	1. Time the patient enters clinic	2. Time the patient is registered/allocated card	3. Time the patient completed vital signs	4. Time the patient starts 1st consultation	5. Time the patient completed 1st consultation	6. Time the patient started 2nd (if referred to another service)	7. Time the patient completed the 2nd consultation (if referred)	8. Time the patient started 3rd (if referred to another service)	9. Time the patient completed the 3rd consultation (if referred)	10. Time the patient arrived at the Pharmacy	11. Time the patient was assisted at the Pharmacy	12.Time the patient departs clinic	Total time spent in facility	Total waiting time spent in facility	Total consultation time spent in facility	Waiting time for registration	Waiting time at Pharmacy	Total waiting time spent in ACUTE stream in facility	Total waiting time spent in CHRONIC stream in facility	Total waiting time spent in MOTHER &CHILD stream in facility
1	NCD	10:00	10:10	10:30	10:40	10:45					11:00	12:00	13:00	03:00	01:40	00:05	00:10	01:00	00:00	00:30	00:00
2	HIV	09:00	09:10	10:20	12:00	12:23	13:02	14:00			14:20	14:55	16:10	07:10	04:14	01:21	00:10	00:35	00:00	03:29	00:00
3	Minor Ailments	08:00	12:00	13:00	13:10	14:20	15:00	15:25	16:05	16:45	17:00	17:34	17:00	09:00	07:04	02:15	04:00	00:34	02:30	00:00	00:00
4	IMCI	08:00	12:00	13:00	13:10	14:20	15:00	15:25	16:05	16:45	16:50	17:10	16:00	08:00	06:50	02:15	04:00	00:20	02:30	00:00	00:00

ANNEXURE 33:

Template to display results of patient experience of care

Results of the PEC survey ..... (year)
(can also be presented in a graph format)

Service area	Target (%)	Score obtained
Access to services	100	
Availability of medicines	95	
Patient safety	80	
Cleanliness and infection prevention and control	80	
Values and attitudes	90	
Patient waiting time	90	
Overall Patient Experience of Care survey results	>80%	

ANNEXURE 34:

Template for commitment of the facility to improve/ sustain the results of the patient experience of care

Operational Plan					
Priority area	**Intention**	**Possible solutions (operational activities)**	**Person responsible for solution (name and area of work)**	**Due date**	**Manager's comment (Outcome)**
Access					
Availability of medicine					
Safety					
Cleanliness and IPC					
Values and attitudes					
Patient waiting time					

Signed commitment:

Facility manager: ..... Sub-district manager: .....

Date: ..... Date: .....

ANNEXURE 35:

Complaints, compliments and suggestions registers

Complaints register

Facility name: ..... **Month/year:** .....

Ref No.	Date received	Complainant's name and surname	Patient's name and surname	Summary description of the complaint	Information on i) action taken, ii) outcome, iii) remedial action	Category of complaint (NCS sub-domain)	Severity of complaint (Risk Rating)	Type of Resolution	Date Resolved	Number of working days to resolve Complaint

Register for compliments

Facility name: ..... **Month/year:** .....

Ref No.	Date received	Name and surname of person giving a compliment	Name and surname of patient	Manner in which it was recorded (verbally/written)	Summary description of the compliment	Action taken

Register for suggestions

Facility name: ..... **Month/year:** .....

Ref No.	Date received	Name and surname of person making suggestion	Manner in which it was recorded (verbally/written)	Summary description of the suggestion	Action taken

ANNEXURE 36:

Statistical data on complaints, compliments and suggestions

Statistical data on complaints

Name of establishment/province: Financial year:

Column name	Indicators					Categories										
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Month	# Complaints received	# Complaints resolved	% Complaints resolved (Column B ÷ Column A) x 100	# Complaints resolved within 25 working days	% Complaints resolved within 25 working days (Column D ÷ Column B) x 100	Staff attitude	Access to information	Physical access	Waiting times	Waiting list	Patient care	Availability of medicines	Safe and secure environment	Hygiene and cleanliness	Other	Total per month (Sum of Columns F to O)
April																
May																
June																
Total Quarter 1																
July																
Aug																
Sept																
Total Quarter 2																
Oct																
Nov																
Dec																
Total Quarter 3																
Jan																
Feb																
March																
Total Quarter 4																
Total																
Average (Total ÷12)																
% for financial year (Total of Column F/G/H/I/J/K/L/M/N/O ÷ Total Column P) x 100																

Statistical data on compliments

Name of establishment/province:								Financial year:				
Column name	**Indicator**	**Categories**										
	A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**
Month	**# Compliments received**	**Staff attitude**	**Access to information**	**Physical access**	**Waiting times**	**Waiting list**	**Patient care**	**Availability of medicines**	**Safe and secure environment**	**Hygiene and cleanliness**	**Other**	**Total per month (Sum of Columns B to K)**
April												
May												
June												
Total Quarter 1												
July												
Aug												
Sept												
Total Quarter 2												
Oct												
Nov												
Dec												
Total Quarter 3												
Jan												
Feb												
March												
Total Quarter 4												
Total												
Average (Total ÷12)												
% for financial year (Total of Column B/C/D/E/F/G/H/I/J/K ÷ Total Column L) x 100												

Statistical data on suggestions

Name of establishment/province:							Financial year:					
Column name	**Indicator**	**Categories**										
	A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**
Month	**# Suggestions received**	**Staff attitude**	**Access to information**	**Physical access**	**Waiting times**	**Waiting list**	**Patient care**	**Availability of medicines**	**Safe and secure environment**	**Hygiene and cleanliness**	**Other**	**Total per month (Sum of Columns B to K)**
April												
May												
June												
Total Quarter 1												
July												
Aug												
Sept												
Total Quarter 2												
Oct												
Nov												
Dec												
Total Quarter 3												
Jan												
Feb												
March												
Total Quarter 4												
Total												
Average (Total ÷12)												
% for financial year (Total of Column B/C/D/E/F/G/H/I/J/K ÷ Total Column L) x 100												

ANNEXURE 37:

Checklist for complaint/compliment/suggestion management records

Use the checklist below to check the availability of records required for effective complaint/compliment/suggestion Management

Scoring – in column for score mark as follows:

Check complaints/compliments/suggestion records for the past three months for statistical data. For complaint letters and redress letters/minutes, check the last five complaints that were resolved for evidence. ***Note:*** *in cases where no complaints, compliments and suggestions were recorded in the past three months the records should still be completed indicating a '0' on statistical forms for the particular months. Registers must also be present indicating in first line of register 'No complaints/compliments/suggestions reported'*

Y (Yes) = available, **N** (No) = not available

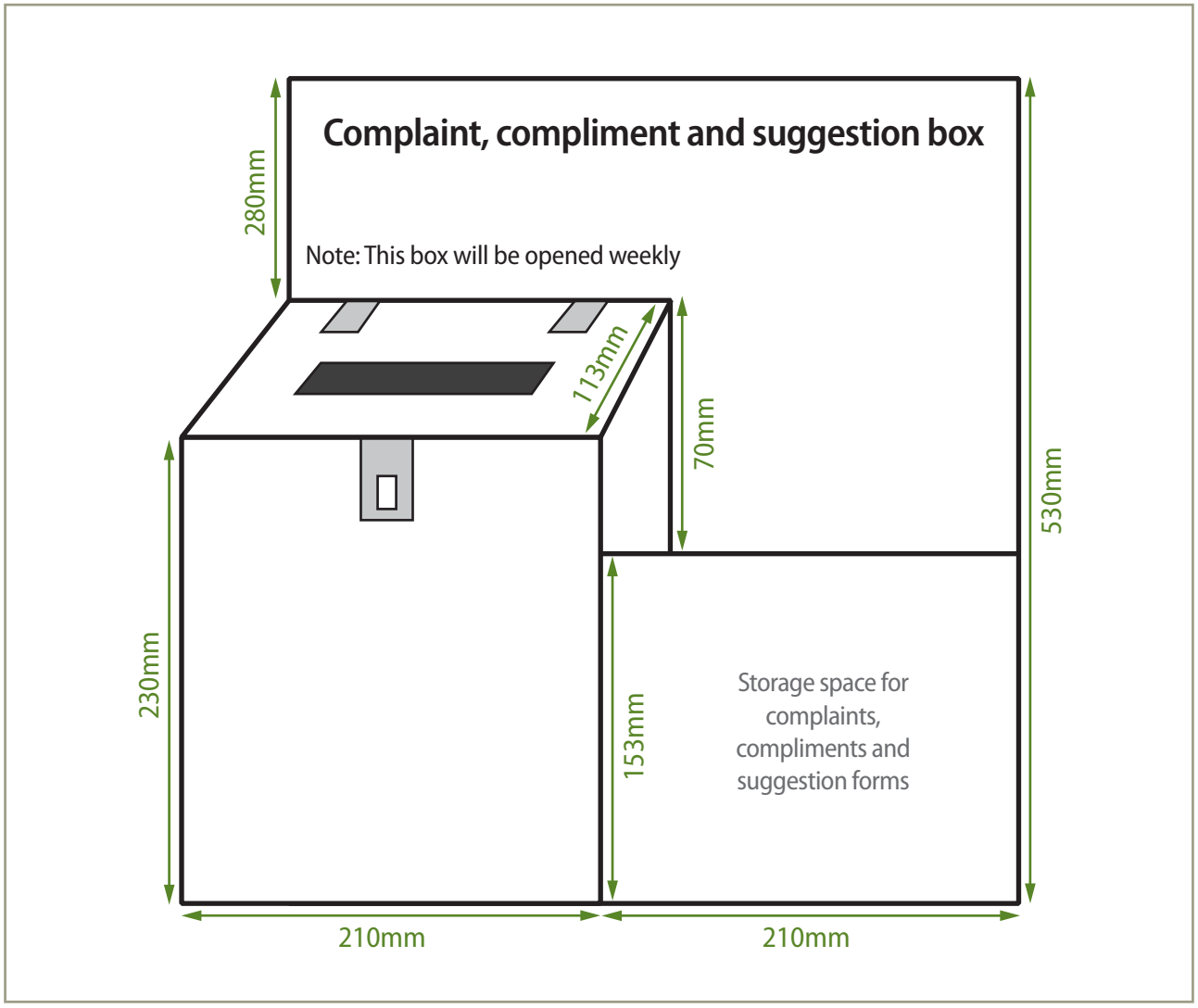
Item	Score
Complaints letters (check the last 5 complaints resolved)	
Complaints redress letters/minutes (check the last 5 complaints resolved)	
Complaints register	
Compliments register	
Suggestion register	
Statistical data on classifications of complaints	
Statistical data on indicators for complaints, compliments and suggestions	
Total score	
Percentage (Total score ÷ 7) x 100	%

Score calculation: Y = 1 N = 0

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 38:

Specifications for complaint, compliment and suggestion boxes



Specifications

Material	Perspex, 5mm thick
Colour	White, frosted
Hinges and hook and eye	Stainless steel
Label	Perspex print on box itself (no labels) in colour as determined by the province (Colour model CMYK: specify colours) **Text and font size:** "Complaint, compliment and suggestion box" – Arial 72 Repeat text translated into two other languages according to most prevalent language in the province "Note: this box will be opened weekly" – Arial 32
Lock	Lock with number sequence to lock
Mounting	Must be mounted onto the wall, 1.2m above the ground.

ANNEXURE 39:

Complaints, compliments and suggestions form

Date completed		Ref no. (office use)	

Do you want to:
(mark the applicable box with an X)

Lodge a complaint ☐ Give a compliment ☐ Make a suggestion ☐

Details of the person lodging a complaint or recording a compliment or suggestion		
Surname		
First name		
Contact details	Cellphone number	
	Postal address	
	Physical address	
If you were admitted, the ward number		
Hospital or clinic file number		
If you are submitting on behalf of someone else, please complete the following:		
Relation to the patient, e.g. mother, etc.		
Patient's surname		
Patient's first name		
Contact details of the patient	Cellphone number	
	Postal address	
	Physical address	
If patient was admitted, the ward number		
Patient's hospital or clinic file number		

Please describe the incident or give a compliment or make a suggestion
* Where possible also record the staff involved and department where the incident took place

Date on which the incident took place:	

Signature of person lodging a complaint or recording a compliment or suggestion

Signature of patient

ANNEXURE 40:

Complaints, compliments and suggestions poster

WHAT YOU SHOULD DO IF YOU WANT TO COMPLAIN, GIVE A COMPLIMENT OR MAKE A SUGGESTION

Lodge a complaint or record a compliment or suggestion

VERBALLY:

Approach the official responsible for managing complaints, compliments and suggestions.

This official is:

Telephone number:

Location of office:

The complaint, compliment or suggestion will be recorded on a prescribed form.

IN WRITING:

Fill in the prescribed form that is available next to the designated box or from the responsible official. The form will guide you on the information needed. Hand over the form to the official or place it in the box provided to post complaints, compliments, or suggestions that is situated at:

Take note: If the complaint is urgent, give it directly to the responsible official as the boxes will only be opened on scheduled times as indicated on the box. *Otherwise:*

Email or

Fax or

Post

ASK A FAMILY MEMBER OR FRIEND:

To submit a complaint, compliment or suggestion on your behalf in writing or verbally

The complaint will be acknowledged within 5 working days

The complaint will be investigated

The complaint will be resolved and redress conducted within 25 working days.
Should the case require more time for investigation, updates will be provided.

Should you be dissatisfied with the outcome, lodge the complaint at the district/provincial office or call centre on:

Should you **still** be dissatisfied with the outcome, lodge the complaint at the:

Presidential Hotline on 17737 **or**

Batho Pele Call Centre on 0860 428 392 **or**

Ombud in the Office of Health Standards Compliance on 012 339 8678 / 012 339 8691 / Complaints@ohsc.org.za

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

EKUFUNEKA UKWENZE UKUBA UFUNA UKUKHALAZA, UKUNCOMA OKANYE UKUNIKA INGCEBISO

Faka isikhalazo okanye bhala isincomo okanye ingcebiso

NGOMLOMO:

Yiya kwigosa elinoxanduva lokulawula izikhalazo, izincomo neengcebiso.

Eli gosa ngu-:

Inombolo yomnxeba:

Indawo ye-ofisi:

Isikhalazo, isincomo okanye ingcebiso ziza kubhaliswa kwifomu emiselweyo

NGOKUBHALA:

Gcwalisa ifomu emiselweyo efumaneka ecaleni kwebhokisi eyalathelwe oko okanye kwigosa elinoxanduva. Ifomu iza kukhokela ngolwazi oludingekayo. Nikeza ifomu kwigosa okanye uyifake kwibhokisi ebekiweyo ukuthumela izikhalazo, izincomo, okanye iingcebiso emi apha:

Qaphela: Ukuba isikhalazo singxamisekile, sinike ngqo igosa elinoxanduva nanjengoko iibhokisi ziza kuvulwa ngamaxesha abekiweyo njengoko kubonakalisiwe kwibhokisi. *Kungenjalo:*

Thumela nge-imeyili okanye

Thumela ngefeksi okanye

Posela apha

CELA ILUNGU LOSAPHO OKANYE UMHLOBO:

Ukuba afake isikhalazo, isincomo okanye ingcebiso egameni lakho ngokubhala okanye ngomlomo

Isikhalazo siza kuqinisekiswa kwiintsuku ezi-5 zokusebenza

Isikhalazo siza kuphandwa

Isikhalazo siza kusonjululwa kuze kuqhutywe isilungiso kwiintsuku ezingama-25 zokusebenza.
Xa le meko inokufuna ixesha elingaphaya lokuba iphandwe, izaziso ziza kunikezwa.

Xa unokuthi ungoneliseki sisiphumo, faka isikhalazo apha KwiSithili/kwiOfisi yePhondo okanye iZiko leMinxeba apha:

Xa unokuthi ungoneliseki kwakhona sisiphumo, faka isikhalazo apha:

Umnxeba kaMongameli wemiCimbi etshisa ibunzi apha 17737 **okanye**

Iziko leMinxeba le-Batho Pele apha 0860 428 392 **okanye**

Ku-Ombud kwiOfisi ye-Health Standards Compliance apha 012 339 8678 / 012 339 8691 / Complaints@ohsc.org.za

IsiXhosa

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

OKUFANELE UKWENZE UMA UFUNA UKUKHALAZA, UKUNCOMA NOMA UKWENZA ISIPHAKAMISO

Faka isikhalazo noma bhalisa isincomo noma isiphakamiso

NGOMLOMO:

Yana kumsebenzi obhekene nokuphathwa kwezikhalazo, izincomo neziphakamiso.

Lo msebenzi ngu:

Inombolo yocingo

Indawo yehhovisi

Isiphakamiso kuzorekhodwa (sizobhalwa) efomini olinikezwe ngokusemthethweni

NGOKUBHALA:

Gcwalisa ifomu olinikezwe ngokusemthethweni elitholakala eceleni kwebhokisi elikhethiwe noma elivela kumsebenzi oqondene nalo. Ifomu lizokuqondisa ngolwazi oludingekayo. Nika umsebenzi ifomu noma lifake ebhokisini elihlinzekelwe izikhalazo, izincomo noma iziphakamiso:

Qaphela: Uma isikhalazo siphuthuma, sinikeze ngqo umsebenzi njengoba amabhokisi azovulwa kuphela ngezikhathi ezihleliwe njengoba kukhonjisiwe ebhokisini. *Okukanye:*

Sithumele nge-imeyili ku- noma ku-

Sifeksele ku- noma ku-

Sifeksele ku-

CELA ILUNGU LOMNDENI NOMA UMNGANE:

Ukuthi lihambise isikhalazo, isincomo noma isiphakamiso egameni lakho ngokubhala noma ngomlomo

Isikhalazo siza kuqinisekiswa kwiintsuku ezi-5 zokusebenza

Isikhalazo sizophenywa

Isikhalazo sizoxazululwa bese ukulungiswa kwaso kwenziwe ezinsukwini zokusebenza 25.
Uma isikhalazo sidinga isikhathi esithe xaxa sokuphenya, kuzohlinzekwa ngolwaziolusha

Uma ungenelisekile ngomphumela, faka isikhalazo lapha Ihovisi leSifunda/leSifundazwe noma Isikhungo Sokushayela Izingcingo:

Uma ungenelisekile ngomphumela, faka isikhalazo lapha:

Inombolo Yokubika KaMongameli ku 17737 **noma**

Isikhungo Sokushayela Izingcingo SeBatho Pele ku 0860 428 392 **noma**

Ku-Ombud eHhovisi Lokuhambisana Namazinga Ezempilo ku 012 339 8678 / 012 339 8691 / Complaints@ohsc.org.za

IsiZulu

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

SEO O SWANETŠEGO GO SE DIRA GE O NYAKA GO NGONGOREGA, GO FA THETO GOBA GO DIRA TŠHIŠINYO

Tsenya ngongorego goba rekhoto ya theto goba tšhišinyo

KA MOLOMO:

Eya go mohlankedi yo a rwelego maikarabelo a go laola dingongorego, ditheto le ditšhišinyo.

Mohlankedi yo ke:

Nomoro ya mogala:

Lefelo la kantoro:

Ngongorego, theto goba tšhišinyo etla rekhotiwa foromong yeo e laetšwego.

KA GO NGWALA:

Tlatša foromo yeo e lego gona kgauswi le lepokisi leo le abilwego goba go tšwa go mohlankedi yo a rwelego maikarabelo. Foromo e tla go hlahla ka tshedimošo yeo e nyakegago. Efa mohlankedi foromo yeo goba e tsenye ka lepokising leo le abilwego la go posa dingongorego, ditheto, goba ditšhišinyo leo le lego:

Ela tlhoko: Ge ngongorego e potlakile, e fe mohlankedi yo a rwelego maikarabelo thwii ka ge mapokisi a tla bulwa fela ka nako yeo e beilwego bjalo ka ge go laeditšwe lepokising. *Go sego bjalo :*

Emeilela go goba

Fekesetša go goba

Posetša go

KGOPELA LELOKO LA LAPA GOBA MOGWERA:

Go iša ngongorego, theto goba tšhišinyo legatong la gago ka go ngwala goba ka molomo

Ngongorego e tla arabiwa mo matšatšing a mošomo a 5

Ngongorego e tla nyakišišwa

Ngongorego e tla rarollwa le tokišo e tla dirwa mo matšatšing a mošomo a 25.
Ge molato o ka nyaka nako ye ntši ya nyakišišo, tshedimošo e tla abiwa.

Ge o sa kgotsofatšwe ke ditetelo, tsenya ngongorego go Kantoro ya Selete/Profense goba Lefelo la Go Lletša Megala go:

Ge o sa kgotsofatšwe ke ditetelo, tsenya ngongorego go:

Mogala wa thwii Kantorong ya Mopresidente go 17737 **goba**

Lefelo la Go Lletša Megala la Batho Pele go 0860 428 392 **goba**

Morarolli Kantorong ya Tatelo ya Maemo a Maphelo ka 012 339 8678 / 012 339 8691 / Complaints@ohsc.org.za

Sepedi

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

SE O TSHWANETSENG GO SE DIRA FA O BATLA GO TSENYA NGONGOREGO, GO ROTLOETSA KGOTSA GO NAYA TSHITSHINYO

Tsenya ngongorego kgotsa thotloetso kgotsa naya tshitshinyo

KA MOLOMO:

Bua le motlhankedi wa taolo le tsamaiso ya dingongorego, dithotloetso le ditshitshinyo.

Motlhankedi yo ke:

Nomoro ya mogala:

Leelo la kantoro:

Ngongorego, thotloetso kgotsa tshitshinyo di tlaa kwalwa mo foromong e e atlenegi-sitsweng.

KA LEKWALO:

Tlatsa foromo e e atlenegisitsweng e e bapileng le lebokoso le le tlhaotsweng kgotsa mo go motlhankedi yo o maleba. Foromo e tlaa go naya tshedimosetso e e tlhokegang. Neela motlhankedi foromo kgotsa o e tsenye mo lebokosong le le tlhaotsweng go posa dingongorego, dithotloetso, kgotsa ditshitshinyo le le fitlhelwang mo:

Ela tlhoko: Fa ngongorego e le ya tshoganyetso, e neele motlhankedi yo o maleba ka tlhamalalo gonne mabokoso a bulwa fela ka dinako tse di rulaganyeditsweng go bulwa jaaka go kailwe mo lebokosong. *Kgotsa:*

Romela imeili go kgotsa

Romela fekese go kgotsa

Posetsa go

KOPA MONGWE WA BALELAPA KGOTSA TSALA:

Go romela ngongorego, kakgololo kgotsa tshitshinyo mo boemong jwa gago ka go kwala kgotsa ka molomo

Go tlaa romelwa kitsiso ya kamogelo ya ngongorego mo malatsing a le 5 a tiro

Ngongorego e tlaa batlisisiwa

Ngongorego e tlaa rarabololwa mme go tlaa dirwa paakanyo mo malatsing a le 25 a tiro.
Fa ngongorego e ka tlhoka nako e ntsi go batlisisiwa, pego ka ga seemo, e tla rebolwa.

Fa o sa kgotsofalele poelo, ngongorega kwa kantoro ya kgaolo/ porofense kgotsa lefelo la megala mo go:

Fa o sa ntse o sa kgotsofalele poelo, ngongorega kwa:

Mogaleng wa tlhaeletsano ya setšhaba le mopresidente mo go 17737 **kgotsa**

Lefelong la megala la Batho Pele mo go 0860 428 392 **kgotsa**

Ombud mo kantorong ya kobamelo ya maemo a pholo
012 339 8678 / 012 339 8691 / Complaints@ohsc.org.za

Setswana

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

VHA NGA ITA MINI U DISA MBILAELO, ZWIKHODO KANA TSIVHUDZO

Kha Vha Dzhenise Mbilaelo, Zwikhodo Kana Tsivhudzo

NGA U AMBA:

Kha vha vhudzise mushumi o imelaho dzimbilaelo, zwikhodo na u tsivhudza.

Mushumi uyu ndi:

Nomboro ya lutingo:

Ofisi yawe i wanala:

Mbilaelo, zwikhodo na tsivhudzo zwi do dzheniswa kha fomo yo teaho.

NGA U NWALA:

Kha vha dadze fomo yo teaho ire tsini na bogisi la tsivhudzo, kana vha wane fomo kha mushumeli wa zwa mbilaelo. Fomo I do vha sumbedza zwi todiwaho. Vha nga nekedza fomo iyo kha uyu mushumeli kana vha I dzhenisa kha bogisi lo netshelwaho u dzhenisa mbilaelo, zwikhodo na tsivhudzo li no wanala:

Vha thogomele: Arali mbilaelo I ya tshiimo tsha shishi, vha nekedze vhahulwane vha henefho sa izwi bogisi li tshi vulwa nga zwifhinga zwo fewaho. *Manwe madisele:*

E-mail kha kana

Fax kha kana

Poso kha

VHA HUMBELE SHAKA KANA KHONANI:

U vha disela mbilaelo, zwikhodo kana tsivhudzo o vha imela.

Mbilaelo I do sumbedzwa u tanganedzwa nga maduvha matanu (5)

Mbilaelo I do sedzuluswa

Mbilaelo I do tandululwa na u dzudzanywa nga maduvha a 25
Arali u sedzulula zwa toda tshifhinga tshilapfu vha do divhadzwa.

Vha sa fushea nga mvelelo vha nga isa mbilaelo phanda kha Nomboro ya tshitiriki/phurovinsi ya mbilaelo:

Arali vha di vha songo fushea vha nga fhirisela mbilaelo kha:

Nomboro ya muphuresidente kha 17737 **kana**

Nomboro ya vha pfanelo dza vhathu kha 0860 428 392 **kana**

Muimeleli kha ofisi ya Health Standards Compliance on 012 339 8678 / 012 339 8691 / Complaints@ohsc.org.za

Venda

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

LESWI U FANELEKE KU SWI LANDZELELA LOKO U LAVA KU YISA SWIVILELO, SWIBUMA-BUMELO NI MAVONELE MAYELANA NI VUKORHOKERI

Yisa swivilelo, swibuma-bumelo kumbe mavonele hi ndlela leyi landzelaka

HI KU VULAVULA:

Fikelela mutirhi loyi a tirhanaka na swivilelo, swibuma-bumelo ni mavonele eka swa vukorhokeri.

Vito ra muofisiri i:

Nomboro ya rinqingo:

Laha a kumekaka kona:

Swivilelo, swibuma-bumelo kumbe mavonelo swita tsariwa eka fomo leyi lulamisiweke.

HI KU TSALA:

Tata fomo ya swivilelo leyi nga kona a kusuhi na bokisi ra swivilelo kumbe eka lava tirhanaka na swona. Fomo ya kombisa mahungu lawa ya lavekaka. Nyika fomo leyi eka mutirhi loyi a tirhanaka na swivilelo kumbe unga ha yi hoxa eka bokisi leri vekiweke ku amukela swivilelo, swibuma-bumelo ni mavonelo leri ri kumekaka e:

Lemuka: Loko xivilelo xiri xa xihatla, nyika muofisiri wa swavukorhokeri evokweni tani hi loko mabokisi ya swibumabulelo na swivilelo ya pfuriwa ntsena hi nkarhi lowu vekiweke, nakambe wu tsariweke eka mabokisi lawa. Loko swinga ri tano, unga ha tirhisa tindlela leti landzelaka:

E-mail eka kumbe

Nomboro ya fax kumbe

Poso eka

KOMBELA UN'WANI WA XAKA KUMBE MUNGHANA:

Ku tsalela kumbe Ku yisa swivilelo, swibuma-bumelo kumbe mavonele a yimela wena.

Swivilelo switа amukeriwa ku nga si hela masiku ya ntlhanu (5) yo tirha

Xivilelo xita lavisisiwa

Xivilelo xa wena xita lulamisiwa yi tlhela hofisi yi kombela ku khomeriwa laha swi nga hoxeka kunga si hela masiku ya ntirho ya 25. *Loko ko tshika ku laveka nkarhi wo engetela leswaku ku lavisisiwa xivangelo, mita tivisiwa nkarhi na nkarhi.*

Loko unga eneriseki hi ndlela leyi xivilelo xa wena xi lulamisiweke ha yona, ungaka yisa swisolo eka hofisinkulu ya xifundzha / provinsi kumbe u fonela ndzhawulo eka:

Loko unga enerisekanga hi mafambiseriwele ya xivilelo xa wena, unga ha yisa xivilelo eka:

U nga ha fonela hofisi ya Presidente eka 17737 **kumbe**

Batho Pele Call Centre eka 0860 428 392 **kumbe**

Mulavisisi hofisini leyi tirhanaka na xiyimo xa vukorokeri etikweni hinkwaro eka 012 339 8678 / 012 339 8691 / Complaints@ohsc.org.za

Xitsonga

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

WAT JY MOET DOEN AS JY 'N KLAGTE WIL INDIEN, KOMPLIMENT WIL GEE OF VOORSTEL WIL MAAK

Die indiening van 'n klagte, kompliment of voorstel

MONDELING:

Nader die beampte wat verantwoordelik is vir die bestuur van klagtes, komplimente en voorstelle.

Die beampte is:

Telefoonnommer:

Ligging van die kantoor:

Die klagte, kompliment, of voorstel sal neergeskryf word op die voorgeskrewe vorm.

GESKREWE:

Vul die voorgeskrewe vorm in wat beskikbaar is langs die aangeduide houer of verkrygbaar is van die verantwoordelike beampte. Die vorm dui aan watter inligting benodig word. Oorhandig die vorm aan die beampte of plaas dit in die houer vir klagtes, komplimente en voorstelle wat geleë is by:

Neem kennis: Indien die klagte dringend is, gee dit direk aan die verantwoordelike beampte, aangesien die houers slegs op geskeduleerde tye oop gemaak sal word soos aangedui op die houers. *Of:*

E-pos na of

Faks na of

Pos na

VRA 'N FAMILIELID OF 'N VRIEND:

Om 'n klagte, kompliment of voorstel namens u in te dien, hetsy mondelings of geskrewe.

Ontvangs-erkenning van die klagte sal binne 5 werksdae geskied

Die klagte sal ondersoek word

Die klagte sal opgelos en terugvoering sal gegee word binne 25 werksdae. *Indien die klagte meer tyd benodig om ondersoek te word, sal u op hoogte gehou word.*

Indien u ontevrede is met die uitkoms, dien u klagte in by die Distrik/Provinsiale kantoor of inbel sentrum:

Sou u nog steeds ontevrede wees met die uitkoms, lê u klag by:

Presidensiële Blitslyn op 17737 **of**

"Batho Pele" Oproepkantoor op 0860 428 392 **of**

Ombud in die "Office of Health Standards Compliance" op 012 339 8678 / 012 339 8691 / Complaints@ohsc.org.za

Afrikaans

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

ANNEXURE 41:

Temperature control chart for medicine refrigerator and medicine room

Daily refrigerator temperature record

Facility: .... **Month/year:** .... **District:** ....

Record temperature at 08:00 and 15:00 daily

Day		1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
Deg. ºC		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
UNSAFE	22																																																															
	20																																																														
	18																																																														
	16																																																														
	14																																																														
	12																																																														
	10																																																														
SAFE	8																																																														
	6																																																														
	4																																																														
	2																																																														
UNSAFE	0																																																														
	-2																																																														
	-4																																																														
	-6																																																														
	-8																																																														
	-10																																																														
Defrost																																																															

** Indicate in the 'Defrost' section of the temperature chart the date and time when the fridge is defrosted.*

Action to take when the temperature moves into the "UNSAFE" range:

1. Check the electricity supply connection. Check the gas supply – is there a spare gas cylinder?
2. Check that the door closes properly. Check that the door has not been left open for a while. Check how often the fridge door is opened. Make sure that the fridge is not overloaded.
3. Check how thick the ice build-up is in the freezing compartment. DEFROST IF THE ICE IS MORE THAN 0.5CM THICK – CLEAN THE FRIDGE REGULARLY.
4. Implement your contingency plan if the fridge is malfunctioning. Notify your supervising pharmacist, sub-district and/or district pharmacy and PHC managers of the challenge.

Daily Medicine Room/Dispensary temperature record

Facility: ..... **District:** ..... **Month/year:** .....

Record temperature daily

Day	Temperature (°C)	Comment*	Day	Temperature (°C)	Comment*
1			17		
2			18		
3			19		
4			20		
5			21		
6			22		
7			23		
8			24		
9			25		
10			26		
11			27		
12			28		
13			29		
14			30		
15			31		
16					

** Indicate action taken when the temperature recorded exceeds 25 °C under the comments section.*

Action to take when the room temperature exceeds 25 °C:

1. Check that the air conditioner is on. If not, check the electricity supply to the air conditioner and switch the air conditioner on.
2. If there are not challenges with the electricity supply but the air conditioner is not on OR if the air conditioner is on but not in good working order, place an urgent works/procurement order for repairs/replacement using district procurement procedures.

ANNEXURE 42:

Essential medicines list for Primary Health Care facilities

ACT	MEDICINE	ACT	MEDICINE
A02BC	Proton-pump inhibitor, oral	B05BB01	Sodium Chloride 0.9%, I.V. solution
A02BC03	Lansoprazole, oral	B05CB01	Sodium Chloride 0.9%, irrigation
A03BA01	Atropine, parenteral	B05XA05	Magnesium sulphate, parenteral
A03BB01	Hyoscine butylbromide, oral	C01CA24	Epinephrine (adrenaline), parenteral
A03FA01	Metoclopramide, oral	C01DA	Nitrates, short acting, oral
A03FA01	Metoclopramide, parenteral	C01DA08	Isosorbide dinitrate, oral
A06AB06	Sennosides A and B, oral	C01DA14	Isosorbide mononitrate, oral
A06AD11	Lactulose, oral	C02AB01	Methyldopa, oral
A07AA02	Nystatin, oral	C03AA	Thiazide Diuretic
A07BA01	Charcoal, activated	C03AA03	Hydrochlorothiazide, oral
A07CA	Oral rehydration solution (ORS)	C03C	Loop Diuretic, oral
A07DA03	Loperamide, oral	C03C	Loop Diuretic, parenteral
A10AB	Insulin, short/rapid acting	C03CA01	Furosemide, oral
A10AC	Insulin, intermediate acting	C03CA01	Furosemide, parenteral
A10AD	Insulin, biphasic	C03DA01	Spironolactone, oral
A10BA02	Metformin, oral	C05AX02	Bismuth subgallate compound, topical
A10BB	Sulphonylureas, oral	C07A	ß-blocker, oral
A10BB01	Glibenclamide, oral	C07AB11	Atenolol, oral
A10BB12	Glimepiride, oral	C07AG	Alpha 1 and non-selective ß blocker, oral
A11B	Multivitamin, oral	C07AG02	Carvedilol, oral
A11CA01	Vitamin A (retinol), oral	C08CA	Calcium channel blocker, long acting, oral
A11DA01	Thiamine (vit B1), oral	C08CA01	Amlodipine, oral
A11EA	Vitamin B Complex, oral	C08CA05	Nifedipine, short-acting, oral
A11HA01	Nicotinamide (vitamin B3), oral	C09A	ACE-Inhibitor, oral
A11HA02	Pyridoxine (vit B6), oral	C09AA02	Enalapril, oral
A12AA04	Calcium carbonate, oral	C10AA	HMGCoA reductase inhibitors (statins), oral
A12CB	Zinc, elemental, oral	C10AA01	Simvastatin, oral
B01AC06	Aspirin, oral	D01AC	Imidazole, topical
B01AD01	Streptokinase, parenteral	D01AC01	Clotrimazole, topical
B02BA01	Vitamin K1 (phytomenodione), parenteral	D01AE12	Salicylic Acid, topical
B03A	Iron, oral	D01AE13	Selenium sulphide, topical
B03AA	Ferrous lactate, oral	D02A	Emollient
B03AA02	Ferrous fumarate, oral	D02AB	Zinc and caster oil ointment
B03AA03	Ferrous gluconate, oral	D02AC	Petroleum Jelly
B03AD03	Ferrous sulphate compound (BPC), oral	D02AX	Aqueous cream (UEA)
B03BB01	Folic Acid, oral	D02AX	Emulsifying ointment
B05BA03	Dextrose, I.V. solution	D04AB01	Lidocaine, topical

D04AB06	Tetracaine, topical	H02AB01	Betamethasone, parenteral
D04AX	Calamine lotion	H02AB07	Prednisone, oral
D05AA	Coal Tar (LPC), topical	H02AB09	Hydrocortisone, parenteral
D07AA02	Hydrocortisone, topical	H03AA01	Levothyroxine, oral
D07AC01	Betamethasone, topical	J01AA02	Doxycycline, oral
D08AC02	Chlorhexidine, topical	J01CA01	Ampicillin, parenteral
D08AG02	Povidone iodine, topical	J01CA04	Amoxicillin, oral
D08AG03	Iodine tincture BP, topical	J01CE02	Phenoxymethylpenicillin, oral
D09AA	Bismuth iodoform paraffin paste (BIPP), topical	J01CE08	Benzathine benzylpenicillin (depot formulation), parenteral
D09AX	Paraffin gauze dressings	J01CF05	Flucloxacillin, oral
D10AD	Retinoids, topical	J01CR02	Amoxicillin/Clavulanic Acid, oral
D10AD01	Tretinoin, topical	J01DB01	Cephalexin, oral
D10AE01	Benzoyl peroxide, topical	J01DD04	Ceftriaxone, parenteral
G01AF02	Clotrimazole, vaginal	J01EE01	Trimethoprim/Sulfamethoxazole (Cotrimoxazole), oral
G02AB03	Ergometrine, parenteral	J01FA	Macrolide, oral
G02AD06	Misoprostol	J01FA01	Erythromycin, oral
G02BA02	Copper IUD	J01FA10	Azithromycin, oral
G03A	Contraceptives. Hormonal for systemic use	J01GB04	Kanamycin, parenteral
G03AA	Contraceptives, monophasic: combined estrogen/ progestin pill	J01MA	Fluoroquinolone, oral
G03AA07	Ethinyloestradiol/levonorgestrel 30mcg/150 mcg, oral	J01MA02	Ciprofloxacin, oral
G03AB	Contraceptives, triphasic: combined estrogen/progestin pill	J01MA14	Moxifloxacin, oral
G03AB03	Levonorgestrel/Ethinyl oestradiol, oral	J01XD01	Metronidazole, oral
G03AC	Contraceptives, levonorgestrel, implant	J02AC01	Fluconazole, oral
G03AC	Contraceptives, monophasic: progestin only pill	J04AB02	Rifampicin (R), oral
G03AC	Contraceptives, progestin only pill	J04AC01	Isoniazid (H/INH), oral
G03AC	Contraceptives, progestin-only injectable, parenteral	H03AA01	Levothyroxine, oral
G03AC	Contraceptives, progestin-only subdermal implant	J01AA02	Doxycycline, oral
G03AC03	Levonorgestrel pill	J01CA01	Ampicillin, parenteral
G03AC06	Contraceptives, medroxyprogesterone acetate depot, parenteral	J01CA04	Amoxicillin, oral
G03AC08	Etonogestrel, implant	J01CE02	Phenoxymethylpenicillin, oral
G03AD	Progestin-only, emergency contraceptive, oral	J01CE08	Benzathine benzylpenicillin (depot formulation), parenteral
G03AD01	Levonorgestrel, emergency contraceptive, oral	J01CF05	Flucloxacillin, oral
G03C	Estrogen, oral	J01CR02	Amoxicillin/Clavulanic Acid, oral
G03CA03	Estradiol valerate, oral	J01DB01	Cephalexin, oral
G03CA57	Estrogens conjugated, oral	J01DD04	Ceftriaxone, parenteral
G03DA02	Medroxyprogesterone acetate, oral	J01EE01	Trimethoprim/Sulfamethoxazole (Cotrimoxazole), oral
G03DC02	Norethisterone acetate, oral	J01FA	Macrolide, oral
G03HA01	Cyproterone acetate, oral	J01FA01	Erythromycin, oral
H01BB02	Oxytocin, parenteral	J01FA10	Azithromycin, oral
H01BB02/ G02AB03	Oxytocin/ergometrine, parenteral	J01GB04	Kanamycin, parenteral

J01MA	Fluoroquinolone, oral	M02AC	Methyl Salicylate Ointment
J01MA02	Ciprofloxacin, oral	M04AA01	Allopurinol, oral
J01MA14	Moxifloxacin, oral	N01AX13	Nitrous Oxide, general anesthetic
J01XD01	Metronidazole, oral	N01BB02	Lidocaine 1%, parenteral
J02AC01	Fluconazole, oral	N01BB02	Lidocaine 2%, parenteral
J04AB02	Rifampicin (R), oral	N01BB52	Lidocaine with epinephrine (adrenaline), parenteral
J04AC01	Isoniazid (H/INH), oral	N02AA01	Morphine, parenteral
J04AD03	Ethionamide, oral	N02AA01	Morphine, oral
J04AK01	Pyrazinamide (Z), oral	N02AB02	Pethidine, parenteral
J04AK02	Ethambutol (E), oral	N02AX02	Tramadol, oral
J04AK03	Terizidone, oral	N02BE01	Paracetamol, oral
J04AM02	Rifampicin/Isoniazid (RH), oral	N03AA02	Phenobarbital (phenobarbitone), oral
J04AM06	Rifampicin/Isoniazid/Pyrazinamide/Ethambutol (RHZE), oral	N03AB02	Phenytoin, oral
J05AB01	Aciclovir, oral	N03AE	Benzodiazepines (antiepileptics)
J05AE03	Ritonavir, oral	N03AF01	Carbamazepine, oral
J05AE08/ J05AE03	Atazanavir/ritonavir, oral	N03AG01	Valproate, oral
J05AF01	Zidovudine, oral	N03AX09	Lamotrigine, oral
J05AF05	Lamivudine, oral	N04A	Anticholinergic agents, oral
J05AF06	Abacavir, oral	N04A	Anticholinergic agents, parenteral
J05AF07	Tenofovir, oral	N04AA02	Biperiden, parenteral
J05AF09	Emtricitabine, oral	N04AB02	Orphenadrine, oral
J05AG01	Nevirapine, oral	N05AA01	Chlorpromazine, oral
J05AG03	Efavirenz, oral	N05AB02	Fluphenazine decanoate, parenteral
J05AR10/ J05AE03	Lopinavir/ritonavir, oral	N05AD01	Haloperidol, parenteral
J06BB01	Anti-D immunoglobulin	N05AD01	Haloperidol, oral
J06BB05	Rabies Immunoglobulin (RIG)	N05AF01	Flupenthixol decanoate, parenteral
J07AG01	Haemophilus Influenzae Type B (Hib) vaccine	N05AF05	Zuclopenthixol acetate, parenteral
J07AL02	Pneumococcal conjugated vaccine (PCV)	N05AF05	Zuclopenthixol decanoate, parenteral
J07AM01	Tetanus toxoid (TT)	N05AX08	Risperidone, oral
J07AM51	Tetanus and diptheria (Td) vaccine	N05BA	Benzodiazepines (anxiolytics)
J07AM51	Diptheria, tetanus and pertussis(DTP) vaccine	N05BA01	Diazepam, oral
J07BB	Influenza vaccine	N05BA01	Diazepam, parenteral
J07BC01	Hepatitis B (HepB) vaccine	N05CD	Benzodiazepines (sedatives)
J07BD01	Measles vaccine	N05CD08	Midazolam, parenteral
J07BF	Oral polio vaccine (OPV)	N06AA	Tricyclic antidepressants, oral
J07BG01	Rabies vaccine	N06AA09	Amitriptyline, oral
J07BH	Rotavirus vaccine	N06AB	Selective serotonin reuptake inhibitors (SSRIs), oral
J07CA09	Hexavalent - diptheria, tetanus, acellular pertussis, inactivated polio, hepatitis B, haemophilus influenza type b vaccine	N06AB03	Fluoxetine, oral
L03AX03	Bacillus Calmette-Guerin (BCG) vaccine	N06AB04	Citalopram, oral
M01A	NSAID, oral	P01AB01	Metronidazole, oral
M01AE01	Ibuprofen, oral	P01BC01	Quinine dihydrochloride, parenteral

P01BE03	Artesunate, parenteral	R03AC02	Salbutamol, inhaler
P01BF01	Artemether/lumefantrine, oral	R05	Cough Syrup
P02BA01	Praziquantel, oral	R06AB04	Chlorphenamine, oral
P02CA01	Mebendazole, oral	R06AD02	Promethazine, parenteral
P02CA03	Albendazole, oral	R06AE07	Cetirizine, oral
P03AC04	Permethrin, topical	S01AA01	Chloramphenicol, opthalmic
P03AX01	Benzyl benzoate, topical	S01EC01	Acetazolamide, oral
R01AA05	Oxymetazoline, nasal	S01FA01	Atropine, opthalmic
R01AA14	Epinephrine (adrenaline), inhalation	S01GA04	Oxymetazoline, opthalmic
R01AD	Corticosteroid, nasal	S01GX01	Sodium Cromoglycate, opthalmic
R01AD05	Budesonide, nasal	S01HA03	Tetracaine (amethocaine), opthalmic
R03AC	ß2 agonist, short acting, inhaler	S01XA03	Sodium Chloride, hypertonic, I.V. solution
R03AK	Long-acting beta2 agonist/corticosteroid combination, inhaler	S02AA10	Acetic acid in alcohol 2%, otological
R03AK06	Salmeterol/fluticasone, inhaler	V03AB15	Naloxone, parenteral
R03BA	Corticosteroids, inhaled	V03AN01	Oxygen
R03BA01	Beclomethasone, inhaler	V06DC01	Dextrose, oral
R03BB01	Ipratropium Bromide, inhaler	V07AB	Water for injection/ sterile water, parenteral

ANNEXURE 43:

Checklist for tracer medication

Use the checklist below to check the availability of tracer medication

Scoring – in column for score mark as follows:

Check available stock in medicine storage room/dispensary

Y (Yes) = available, **N** (No) = not available

Item	Score	Item	Score
Medicine storage room			
Oral formulations/inhalers			
Abacavir syrup 20mg/ml		Methyldopa 250 mg tablets	
ACE-Inhibitors: e.g. Enalapril 10mg tablets		Metronidazole 200mg OR 400mg tablets	
Amlodipine 5mg tablets		Nevirapine 50mg/5mL suspension	
Amoxicillin 250mg OR 500mg capsules		Oral rehydration solution	
Amoxicillin suspension 125mg/5mL OR 250mg/5mL		Paracetamol 120mg/5mL syrup	
Aspirin tablets		Paracetamol 500mg tablets	
Azithromycin 250mg OR 500mg tablets		Carbamazepine tablets 200mg OR lamotrigine 25mg tablets	
Corticosteroid inhaler e.g. Beclomethasone inhaler 100mcg and 200 mcg		Prednisone 5mg tablets	
Co-trimoxazole 200/40mg per 5mL (100ml)		Pyrazinamide 500mg tablets	
Co-trimoxazole 400/80mg tablets		Pyridoxine 25mg tablets	
Ferrous lactate/gluconate suspension		RH (Rifampicin + Isoniazid) 300mg/150mg OR 150/75mg	
Ferrous sulphate/fumarate tablets		RH (Rifampicin + Isoniazid) 60/60 tablets	
Folic acid 5 mg tablets		RHZE (Rifampicin + Isoniazid + pyrazinamide + ethambutol)	
HMG CoA reductase inhibitors, e.g. Simvastatin 10 mg tablets		Short acting β2 agonist inhaler e.g Salbutamol	
Hydrochlorothiazide 12.5mg OR 25mg tablets		Tenofovir/emtricitabine/efavirenz 300/200/600mg tablets	
Ibuprofen 200 mg OR 400mg tablets		Vitamin A 50 000U OR 100 000U OR 200 000U capsule	
Isoniazid 100mg OR 300mg tablets		Zidovudine 50mg/5mL suspension	
Metformin 500mg OR 850mg tablets			
Injections			
Benzathine benzylpenicillin 2.4MU vial		Medroxyprogesterone acetate 150mg/ml injection OR norethisterone 200mg/ml	
Ceftriaxone 500mg OR 1g ampoules			
Topicals			
Chloramphenicol 1%, ophthalmic ointment			

Fridge			
BCG vaccine		Pneumococcal Conjugated Vaccine (PCV)	
Insulin, short acting		Polio vaccine (oral)	
Measles vaccine		Rotavirus vaccine	
Hexavalent: DTaP-IPV-HB-Hib vaccine		Tetanus toxoid (TT) vaccine	
Oxytocin 5 OR 10 IU/ml OR oxytocin/ergometrine combination)			
Emergency trolley			
Adrenaline Injection 1mg/ml (Epinephrine)		Magnesium sulphate 50%, 2ml ampoule	
Dextrose 10% OR 50% intravenous solution		Nifedipine 5mg OR 10mg capsules	
Furosemide 20mg ampoule		Sodium chloride 0.9% 1L	
Isosorbide dinitrate, sublingual, 5 mg tablets		Midazolam (1mg/ml OR 5mg/ml) OR Diazepam 5mg/ml	
Total score/30		**Total score/26**	
Percentage (sum of 2 total scores ÷ 56) x 100	%		

Score calculation: Y = 1 N = 0

Percentage obtained	Score
90%	Green
40-89%	Amber
< 40%	Red

ANNEXURE 44:

Checklist for basic surgical supplies (consumables)

Use the checklist below to check the availability of surgical and dressing supplies

Scoring – in column for score mark as follows:

Check available stock in storage room

Y (Yes) = available, **N** (No) = not available , **NA** (not applicable) = sections marked as "only applicable if the facility..."

Surgical supplies			
Item	**Score**	**Item**	**Score**
Admin set 20 drops/ml 1.8m /pack		Gloves exam n/sterile large /box	
Admin set paeds 60 drops/ml 1.8m /pack		Gloves exam n/sterile medium /box	
Blade stitch cutter sterile short /pack		Gloves exam n/sterile small /box	
Blood collecting vacutainer (holding barrel/bulldog)		Gloves surg sterile latex sz 6.5 /box	
Blood lancets (haemolance)		Gloves surg sterile latex sz 7 /box	
Endotracheal tubes - uncuffed 2.5mm		Gloves surg sterile latex sz 7.5 /box	
Endotracheal tubes - uncuffed 3.5mm		Gloves surg sterile latex sz 8 /box	
Endotracheal tubes - uncuffed 4.5mm		Intravenous cannula (Jelco) *14g* orange/box	
Endotracheal tubes - cuffed 5.0mm		Intravenous cannula (Jelco) *18g* green/box	
Endotracheal tubes - cuffed 6.0mm		Intravenous cannula (Jelco) *20g* pink/box	
Endotracheal tubes - cuffed 6.5mm		Needles: 18 (pink) OR 20 (yellow)/box	
Endotracheal tubes - cuffed 7.0mm		Needles: 21 (green)/box	
Endotracheal tubes - cuffed 7.5mm		Needles: 23 (blue)/box OR 22 (black)/box	
Endotracheal tubes - cuffed 8.0mm		* Syringes 3-part 2ml/box	
Urinary (Foley's) catheter silicone/latex 10f		* Syringes 3-part 5ml/box	
Urinary (Foley's) catheter silicone/latex 14f		* Syringes 3-part 10 or 20ml/box	
Urinary (Foley's) catheter silicone/latex 18f		Insulin syringe with needle /box	
Urine drainage bag 750ml		Introducers for endotracheal tubes OR bougie with adult stylets	
Oropharyngeal airways (Guedel) size 0		Introducers for endotracheal tubes OR bougie with paediatric stylets	
Oropharyngeal airways (Guedel) size 1		Suture chromic g0/0 or g1/0 1/2 75cm	
Oropharyngeal airways (Guedel) size 2		Suture nylon g2/0 3/8 45cm	
Oropharyngeal airways (Guedel) size 3		Suture nylon g3/0 3/8 45cm	
Oropharyngeal airways (Guedel) size 4		Suture nylon g4/0 3/8 45cm	
Oropharyngeal airways (Guedel) size 5		Tongue depressor wood	
Laryngeal masks (supraglottic airways): Neonate/ infant size 1 OR 1.5		Disposable aprons	
Laryngeal masks (supraglottic airways): Paediatric size 2 OR 2.5		Eye patches (disposable)	

Laryngeal masks (supraglottic airways): Adults any one of the sizes 3 to 5		Disposable razors	
Simple face mask OR reservoir mask OR nasal cannula (prongs) for oxygen, adults		Nasogastric feeding tube 600mm fg5	
Simple face mask OR reservoir mask OR nasal cannula (prongs) for oxygen, paediatric		Nasogastric feeding tube 600mm fg8	
Face mask for nebuliser OR face mask with nebuliser chamber for adult		Nasogastric feeding tube 1000mm fg10	
Face mask for nebuliser OR face mask with nebuliser chamber for paediatric			
Only applicable if the facility uses older HB model			
Haemolysis applicator sticks		HB Chamber glass-grooved	
HB meter clip		HB Cover glass-plain	
Only applicable if the facility uses an Automatic External Defibrillator (AED)			
Replacement pads for AED - adult		Replacement pads for AED - paediatric	
Only applicable if the facility has a permanent doctor			
Disposable Amnihook		Dental syringe and needle for LA	
Ultrasound gel medium viscosity			
Sub Total 1 for surgical supplies		**Sub Total 2 for surgical supplies**	
Sub maximum score 1 (sum of all scores minus the ones marked NA)		**Sub Maximum score 2** (sum of all scores minus the ones marked NA)	

Dressing supplies					
Item	**Pack size**	**Score**	**Item**	**Pack size**	**Score**
Elastoplast plaster roll	1		Sanitary towels maternity /pack	12	
Bandage crepe	1		Tampons	10/20	
Gauze paraffin 100x100 /box	1		Stockinette 100mm OR150mm/roll	1	
Gauze swabs plain n/s 100x100x8ply/pack	100		Adhesive micro-porous surgical tape 24mm or 48mm	1	
Gauze abs grade 1 burn 225x225x16 /pack	1		Adhesive micro-porous surgical tape 12mm	1	
Basic disposable dressing pack	1		Webcol 24x30 1ply /box	200	
Cotton wool balls 1g 500's	1				
Sub Total 1 for dressing supplies			**Sub Total 2 for dressing supplies**		
Total score for surgical and dressing supplies					
Total maximum score for surgical supplies (sum of all scores minus the ones marked NA) **and dressing supplies**					
Percentage (Total score ÷ Total maximum score) x 100					%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
90%	Green
40-89%	Amber
< 40%	Red

ANNEXURE 45:

Checklist for diagnostic equipment and concurrent consumables for point of care testing

Use the checklist below to check the availability of laboratory equipment and consumables

Scoring – in column for score mark as follows:

Y (Yes) = available, **N** (No) = not available , **NA** (not applicable) = only for Malaria rapid strips. In areas where Malaria is not prevalent, Malaria rapid strips to be marked NA

Item	Score
Hb meter	
Blood glucometer	
Glass slides	
Lancets	
Blood glucose strips	
Urine dipsticks	
Urine specimen flasks	
Spare batteries	
Malaria rapid test (where applicable)	
Rapid HIV test	
Rh 'D' (Rhesus factor) test	
Total score (total score laboratory equipment + consumables + stationery)	
Total maximum possible score (sum of all scores minus the ones marked NA)	
Percentage (Total score ÷ Total maximum possible sore) x 100	%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 46:

Checklist for required specimen collection materials and stationery

Use the checklist below to check whether specimen collection materials and stationery are available

Scoring – in column for score mark as follows:

Y (Yes) = available, **N** (No) = not available

Item	Score
Vacutainer tube: Blue Top (Sodium Citrate)	
Vacutainer tube: Yellow Top (SST)	
Vacutainer tube: Yellow Top (SST-Paeds)	
Vacutainer tube: Grey Top (Sodium Fluoride)	
Vacutainer tube: White Top	
Vacutainer tube: Purple Top (EDTA)	
Vacutainer tube: Purple Top (EDTA Paeds)	
Sterile specimen jars	
Swabs with transport medium	
Sterile Tubes (without additive) for MCS (Microscopy, culture band sensitivity)	
Venipuncture needles (Green)	
Specimen plastic bags	
Pap smear collection materials	
Fixative	
Wooden spatula	
Slide holder	
Microscope slides	
Early Infant Diagnosis (EID) collection material	
DBS PCR Kit	
NHLS stationery	
Request forms	
PHC Request Form	
Cytology Request Form	
PHC Order Book Material for specimen collection	
PHC Facility Specimen Register	

Total score	
Percentage (Total score ÷ 21) x 100	%

Score calculation: Y = 1 N = 0

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

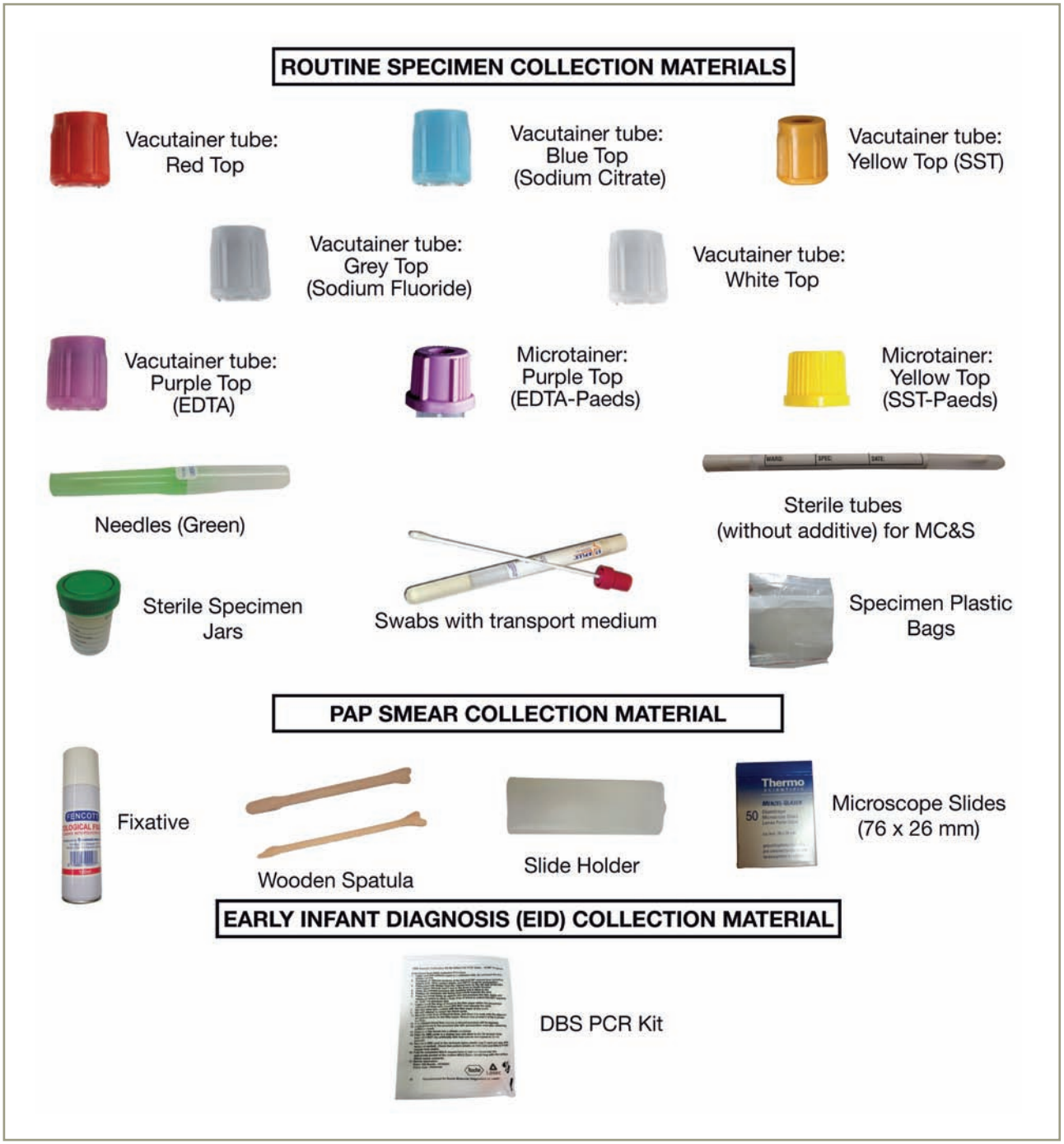


Illustration of NHL specimen collection materials

Use the correct specimen collection material as per specimen key next to each test

Specimen collection material	Key
Vacutainer tube: Red Top	R
Vacutainer tube: Blue Top (Sodium Citrate)	BL
Vacutainer tube: Yellow Top (SST) and (SST-Paeds)	Y
Vacutainer tube: Grey Top (Sodium Fluoride)	G
Vacutainer tube: White Top	W
Vacutainer tube: Purple Top (EDTA) and (EDTA Paeds)	P
Sterile specimen jars	SJ
Dried blood spot	DBS

Test	Specimen collection material	Test	Specimen collection material
Chemical pathology			
ALP (Alkaline Phosphatase)	Y	Phenytoin	Y
ALT(Alanine Transaminase)	Y	Pleural effusion Protein	R
Amylase/Lipase	Y	Potassium (serum)	Y
Calcium (serum)	Y	Prostate-Specific Ag (PSA)	Y
Cholesterol	Y	Sodium (serum)	Y
Creatinine (eGFR) (serum)	Y	Total Bilirubin	Y
CRP (C-reactive protein)	Y	Triglycerides	Y
Folate (serum)	P	TSH (Thyroid-stimulating hormone)	Y
FT4 (Free Throxine 4)	Y	Uric Acid (serum)	Y
Gamma GT (GGT) (Serum)	Y	Urine albumin:creatinine ratio	SJ
Glucose	G	Urine protein:creatinine ratio	SJ
HbA1c (Glycated Haemoglobin)	Y	Vitamin B12	Y
LDL-Cholesterol (LDL-C)	Y		
Haematology		**Microbiology**	
Differential count	P	CRAG (Cryptococcal Antigen test)	Y
Full Blood Count (FBC)	P	Hepatitis A IgM	Y
Haemoglobin	P	Hepatitis B Surface Ab	Y
INR (International Normalized Ratio)	B	HIV Elisa (discordant rapids)	Y
Platelets	P	Stool parasites	SJ
Red Cell Antibody screen (Coomb's Test)	P	Syphilis Serology	Y
White Blood Cell (WBC)	P	MCS (Microscopy, culture band sensitivity)	
HIV viral load		**TB testing**	
HIV Viral Load	W/P	Xpert MTB/RIF	SJ
HIV DNA PCR		TB Smear microscopy	SJ
HIV DNA PCR	DBS/P	TB Culture	SJ
HIV CD4 Count		TB Drug Susceptibility	SJ
CD4 Count	P	TB Line Probe Assay (Hain MTBDR)	SJ
Blood grouping			
ABO (Blood grouping)	Y		
Rhesus Factor (Rh)	Y		

ANNEXURE 47:

Checklist for handling of specimens according to the PHC laboratory handbook

Use the checklist below to check whether specimens are handled according to the PHC Laboratory Handbook

Scoring – in column for score mark as follows:

Check three samples from each of the groups of specimens (A to C) as listed in table 1 and check whether they comply with the guidelines provided

Y (Yes) = handled correctly, **N** (No) = not handled correctly, **NA** (Not applicable) = NA if the facility does not have the specific group of specimen in storage according to Table 1

Table 1: Grouping of specimens

Group A	Group B	Group C
Blood Pleural effusion Sputum Stool Urine	Pap smear	MCS (Microscopy, culture band sensitivity)

Item	Group A			Group B			Group C		
	Score Sample 1	Score Sample 2	Score Sample 3	Score Sample 1	Score Sample 2	Score Sample 3	Score Sample 1	Score Sample 2	Score Sample 3
General									
Specimens are clearly labeled									
Each laboratory request form is correctly completed									
There is at least one functional wall mounted thermometer in area for lab specimens are stored for courier collection									
The temperature of the storage area for lab specimens is recorded daily									
Group A specimens									
Samples kept away from direct sunlight									
Where room temperature exceeds 25°C, samples should be stored in the fridge (± 5°C)									
Length of storage does not exceed 24 hours, stored at room temperature 20-25°C									
Group B specimens									
Stored at room temperature									
Stored inside a slide carrier (envelope)									

Group C specimens									
Samples placed into the transport medium provided (where appropriate)									
Samples kept away from direct sunlight									
Where room temperature exceeds 25°C, samples should be stored in the fridge (± 5°C)									
Length of storage does not exceed 24 Hours, stored at Room temperature 20-25°C									
Score									
Maximum possible score (sum of all scores minus the ones marked NA)									
Total score for all samples									
Total maximum possible score (sum of all sample scores minus the ones marked NA)									
Percentage (Total score ÷ Total maximum possible score) x 100									%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 48:

Checklist for turnaround times of laboratory results

Use the checklist below to check whether the turnaround times for laboratory results are in line with the specified turnaround times

Scoring – in column for score mark as follows:

Check register for sending and receiving laboratory results, check three records

Y (Yes) = results received within specified turnaround time, **N** (No) = results NOT received within specified turnaround time, **NA** (Not applicable) = if the specific result (listed under point 1 to 9) is not in the record

No	Item	Turnaround time	Score record 1	Score record 2	Score record 3
1	All Blood results except those listed in number 2 and 3	24 hours			
2	Blood results: Cholesterol, CRP (C-reactive protein), FT4 (Free Throxine 4), HbA1c (Glycated Haemoglobin), Phenytoin, lipase, PSA (Prostate specific hormone), Red Cell Folate, Triglycerides, TSH (Thyroid stimulating hormone), Vitamin B12, CD4 Count, RPR(Rapid Plasma Reagin test for syphilis), Hepatitis A, B or C	24 to 48 hours			
3	Blood results: HIV PCR for infants, Viral Load	48 to 120 hours			
4	Pap smear	Variable depending on the result (4-6 weeks)			
5	MCS (Microscopy,culture band sensitivity)	24 to 72 hours			
6	Sputum: TB	Between 5 days and 6 weeks			
7	Sputum: Xpert MTB/RIF	24 hours			
8	Stool	24 hours			
9	Urine	24 hours			
Score					
Maximum possible score (sum of all scores minus the ones marked NA)					
Total score for all 3 samples checked					
Total maximum possible score (sum of all samples checked minus the ones marked NA)					
Percentage (Total score ÷ Total maximum possible score) x 100					%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 49:

Work allocation schedule for staff

Date from		Date to		
Name and surname of staff member	**Designation**	**Service area**	**Date**	**Signature**

ANNEXURE 50:

Schedule for acknowledgement of policies/guidelines/protocols/SOP/notifications

Facility name: ..... **Document name:** .....

Name and surname	Persal number	Designation	Date	Signature

ANNEXURE 51:

Annual leave schedule

Annual leave schedule (first 6 months)

Facility name: ..... **Year:** .....

Month	January				February				March				April				May				June			
Name and surname of staff member	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4
Example: Mr XY																								
Example: Ms DB																								
Example: Mr TT																								

Annual leave schedule (second 6 months)

Facility name: ..... **Year:** .....

Month	July				August				September				October				November				December			
Name and surname of staff member	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4
Example: Ms FF																								
Example: Ms DG																								
Example: Mr DT																								

ANNEXURE 52:

Staff satisfaction survey

Rate the questions below as follows:

Disagree =1, **Slightly disagree** = 2, **Slightly agree** = 3, **Agree** = 4, **Strongly agree** = 5

ID	Question	Score				
1	**Staff Satisfaction Survey**	**1**	**2**	**3**	**4**	**5**
1.1	**Personal profile**					
1.1.1	Facility name:					
1.1.2	Occupational class:					
1.1.3	Occupational band:					
1.1.4	Race:					
1.1.5	Gender:					
1.1.6	Age group:					
1.1.7	Years of service:					
1.1.8	Language:					
1.2	**Survey questions (score ranges from 0 to 5)**					
1.2.1	**Direction/strategy/integration**					
1.2.1.1	I am clear on what the Department of Health's strategies and goals are and my role in supporting their attainment					
1.2.1.2	The Department of Health's strategies and goals directly supports those of the National Deaprtment of Health					
1.2.1.3	I am aware of the initiatives to create better integration of policies and coordination across units					
1.2.1.4	The implementation of integration policies will optimise use of resources and enhance efficiencies					
1.2.1.5	Management actively supports the integration initiatives					
1.2.2	**Morale**					
1.2.2.1	I feel valued as an employee					
1.2.2.2	I enjoy being a part of this organisation					
1.2.2.3	Employees have a good balance between work and personal life					
1.2.2.4	Morale is high across the organisation					
1.2.2.5	Employees speak highly about this organisation					
1.2.3	**Workload**					
1.2.3.1	There is enough staff employed to meet work demands in the organisation					
1.2.3.2	I am given enough time to do my job well					
1.2.3.3	Sufficient time is available to work on agreed high priority activities					
1.2.4	**Wellbeing and security**					
1.2.4.1	I feel in control and on top of things at work					
1.2.4.2	I feel emotionally well at work					
1.2.4.3	I am able to keep my job stress at an acceptable level					
1.2.4.4	I feel safe in my work environment					

1.2.5	**Job satisfaction**					
1.2.5.1	My work gives me a feeling of personal accomplishment					
1.2.5.2	I like the kind of work I do					
1.2.5.3	Overall I am satisfied with my job					
1.2.6	**Organisation commitment**					
1.2.6.1	I feel a sense of loyalty and commitment to the organisation					
1.2.6.2	I am proud to tell people that I work at DoH					
1.2.6.3	I feel emotionally attached to the organisation					
1.2.6.4	I am willing to put in extra effort for the organisation					
1.2.7	**Diversity**					
1.2.7.1	Diversity among staff is valued					
1.2.7.2	Sexual harassment is prevented and discouraged at the organisation					
1.2.7.3	Discrimination is prevented and discouraged at the organisation					
1.2.7.4	Bullying and abusive behaviours are prevented and discouraged at the organisation					
1.2.7.5	There is equal opportunity for all staff in the organisation					
1.2.7.6	The organisation has effective procedures for handling employee grievances					
1.2.7.7	Management provides support to staff in reporting any discrimination or harassment					
1.2.8	**Change and innovation**					
1.2.8.1	Change is handled well in the organisation					
1.2.8.2	The way the organisation is run has improved over the last year					
1.2.8.3	The organisation is innovative					
1.2.8.4	The organisation is good at learning from its mistakes and successes					
1.2.9	**Comments**					
1.2.9.1	Please provide any suggestions or recommendations you have to improve performance across the organisation					
1.2.10	**Client orientation and quality of service**					
1.2.10.1	We understand the specific needs of our clients (people we provide service to)					
1.2.10.2	We are focused on delivering high-quality and timeous services to our clients					
1.2.10.3	We have sufficient facilities equipment and supplies to deliver quality service					
1.2.10.4	Our services meet our clients' needs					
1.2.10.5	Department of Health's services are accessible to the community.					
1.2.10.6	Department of Health's services are well known and appreciated in the community.					
1.2.11	**Employee/management relations**					
1.2.11.1	Management sets high standards of excellence					
1.2.11.2	Management creates an environment where employees are enabled to perform their jobs well					
1.2.11.3	Management values the role that unions play in the organisation					
1.2.11.4	Management and unions engage in constructive conflict resolution					
1.2.11.5	Management encourages collaboration across the organisation					
1.2.11.6	Management treats employees fairly					
1.2.12	**Respect**					
1.2.12.1	I feel my input is valued by my peers					
1.2.12.2	Knowledge and information sharing is a group norm across the organisation					

1.2.12.3	Employees consult each other when they need support					
1.2.12.4	Individuals appreciate the personal contributions of their peers					
1.2.12.5	When disagreements occur they are addressed promptly in order to resolve them					
1.2.13	**Role clarity**					
1.2.13.1	The organisation's goals and objectives are clear to me					
1.2.13.2	Employees have a shared understanding of what the organisation is supposed to do					
1.2.13.3	Roles and responsibilities within the group are understood					
1.2.13.4	Clear reporting structures have been established					
1.2.13.5	Employees at this organisation have the right skill sets to perform their job functions					
1.2.13.6	My role has a clearly defined performance expectation					
1.2.14	**Performance/reward systems**					
1.2.14.1	People are involved in setting their own performance goals					
1.2.14.2	People are recognised for achieving their goals					
1.2.14.3	People are rewarded for the quality of their work					
1.2.14.4	There is a clear link between performance and rewards					
1.2.14.5	Management gives feedback that is specific enough to be used for improving their performance					
1.2.14.6	When people do not perform up to their potential action is taken to help them improve and grow					
1.2.14.7	People are rewarded for team efforts not only individual performance					
1.2.15	**Communication**					
1.2.15.1	I receive the information I need to perform my job well					
1.2.15.2	When I need help I can ask others in my work group for suggestions or ideas					
1.2.15.3	Interpersonal communication and relationships contribute to organisational performance					
1.2.15.4	Our face-to-face meetings are productive					
1.2.15.5	The organisation uses effective methods to communicate important information					
1.2.16	**Career development**					
1.2.16.1	When a position needs to be filled in this organisation the best person for the job is the one who gets it					
1.2.16.2	The organisation continuously invests in developing the skills of its employees					
1.2.16.3	The organisation has effective training and education programmes to assist people to do their jobs effectively					
1.2.16.4	My responsibilities include challenging goals that encourage personal growth					
1.2.16.5	The organisation actively retains scarce talent required for efficient quality care					
1.2.17	**Decision-making/management structures**					
1.2.17.1	The structure of the organisation supports cooperation between functions and departments					
1.2.17.2	I believe that the organisation manages its finances responsibly					
1.2.17.3	The organisation supports the implementation of Batho Pele principles to ensure that poor people are not further disadvantaged by the system					
1.2.17.4	There are clear policies and procedures for how work is to be done					
SUB TOTAL SCORE (add the scores in each column)						
TOTAL (add sub total scores						
AVERAGE PERCENTAGE (total/(109*5)						%

ANNEXURE 53:

WISN guidelines on required number of cleaners

Core HRH	SET A: Operation hours		SET B:		SET C:	
	Open 5 days and 8 hours		Open 7 days, 12 hours daily		Open 7 days, 24 hours daily	
	Standard normative guides		Added (12*7*52/191/8) = 3 to the Standard Normative guides in SET A		Added (24*7*52/191/8) = 6 to the Standard Normative guides in SET A	
	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
Cleaner	1	2	4	5	7	8

ANNEXURE 54:

Checklist for cleaning material in stock

Use the checklist below to check whether the relevant cleaning materials are available

Scoring – in column for score mark as follows:

Y (Yes) = available, **N** (No) = not available

Cleaning material	Score
Chlorine compounds (bleach or Clorox)	
Glutaraldehydes (high level disinfection for medical equipment)	
Sanitary all-purpose cleaner	
Janitor trolley	
Green or blue buckets for clean water for janitor trolley	
Red bucket for dirty water for janitor trolley	
Red cloths for toilet	
White cloths for kitchen	
Blue cloths for consulting rooms	
Spray bottle (containing dish washing detergent – disinfectant solution)	
Window cleaning squeegee	
Mop sweeper or soft-platform broom	
Water and detergent-based solutions	
Protective polymer (strippers)	
Total score	
Percentage (Total score ÷ 14) x 100	%

Score calculation: Y = 1 N = 0

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 55:

Control sheet for sign-off for cleanliness of toilets

Faciliy name: ..... **Date:** .....

Area	Monday		Tuesday		Wednesday		Thursday		Friday		Notes
	Time		Time		Time		Time		Time		
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	
Floor											
Basins (clean)											
Clean flowing water											
Hand soap											
Mirrors											
Toilets (clean)											
Toilets (flushing)											
Sanitary bins lids are functional											
Sanitary bins are lined											
Toilet paper											
Urinals											
Disposable towels											
All bins are clean and lined											
Other											

The cleaner must sign/initial in the appropriate space in regard to times for cleaning.

ANNEXURE 56:

Schedule for cleaning times

Take into account busy times in the facility and schedule cleaning times accordingly

Faciliy name: ..... **Week ending:** ..... / ..... / .....

Area	Frequency	Time		
		AM	MID	PM
Administration area	Daily			
Computer room	Daily			
Consulting rooms	Daily			
Corridor	Daily			
Guard room	Daily			
Kitchen	Daily			
Meeting rooms	Daily			
Offices	Twice weekly			
Outside areas	Weekly			
Reception area	Daily			
Restrooms	Daily			
Staff rooms	Twice weekly			
Stair ways (if necessary)	Twice weekly			
Store rooms	Weekly			
Waiting rooms	Daily			

ANNEXURE 57:

Checklist for cleanliness of service areas

Use the checklist below to check whether the various service areas are clean

Scoring – in column for score mark as follows:

Randomly select two service areas as indicated in the column for the score

Y (Yes) = adheres to prompt, **N** (No) = does not adhere to prompt, **NA** (Not applicable) = if there are fewer areas in the clinic than the scoring is indicated for

Area and prompts	**Scores**	
Consulting rooms	**Consulting room 1**	**Consulting room 2**
Windows clean		
Window sills clean		
Floor is clean		
Wall skirting is free of dust		
The counter tops are clean		
The door handles are clean		
Mirrors are clean		
Walls are clean		
Bins are not overflowing		
Bins are clean		
The areas are odour-free		
All areas free of cobwebs		
Score for consulting rooms		
Maximum possible score for consulting rooms (sum of all scores minus the ones marked NA)		
Percentage for consulting rooms (Score ÷ Maximum possible score) x 100		%
Vital signs rooms	**Vital signs room 1**	**Vital signs room 2**
Windows clean		
Window sills clean		
Floor is clean		
Wall skirting is free of dust		
The counter tops are clean		
The door handles are clean		
Mirrors are clean		
Walls are clean		
Bins are not overflowing		
Bins are clean		
The areas are odour-free		

All areas free of cobwebs		
Score for vital signs rooms		
Maximum possible score for vital signs rooms (sum of all scores minus the ones marked NA)		
Percentage for vital signs rooms (Score ÷ Maximum possible score) x 100		%
Waiting areas	**Waiting area 1**	**Waiting area 2**
Windows clean		
Window sills clean		
Floor is clean		
Wall skirting is free of dust		
The counter tops are clean		
The door handles are clean		
Walls are clean		
Bins are not overflowing		
Bins are clean		
The areas are odour-free		
All areas free of cobwebs		
Score for waiting areas		
Maximum possible score for waiting areas (sum of all scores minus the ones marked NA)		
Percentage for waiting areas (Score ÷ Maximum possible score) x 100		%

Summary for cleanliness of service areas

Area	Score	Maximum possible score
Consultation rooms		
Vital signs rooms		
Waiting areas		
Total score/Total maximum possible score		
Percentage (Total score ÷ Total maximum possible score) x 100		%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
90%	Green
40-89%	Amber
< 40%	Red

ANNEXURE 58:

Checklist for running water and consumables in toilets

Use the checklist below to check whether there is running water, toilet paper, liquid hand wash soap and disposable hand paper towels

Scoring – in column for score mark as follows:

Randomly select two toilets, two consulting rooms and two vital signs room to review

Y (Yes) = available, **N** (No) = not available, **NA** (Not applicable) = if the facility has less than the number of areas indicated for review: score available areas

Item	**Scores**	
Toilets	**Toilet 1**	**Toilet 2**
Running water		
Toilet paper		
Liquid hand wash soap		
Disposable hand paper towels		
Consultation rooms	**Consultation room 1**	**Consultation room 2**
Liquid hand wash soap		
Disposable hand paper towels		
Vital signs rooms	**Vital signs room 1**	**Vital signs room 2**
Liquid hand wash soap		
Disposable hand paper towels		
Score		
Maximum possible score (sum of all scores minus the ones marked NA)		
Total score for all areas		
Total maximum possible score (sum of all 3 areas minus the ones marked NA)		
Percentage (Total score ÷ Total maximum possible score) x 100		%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	**Score**
100%	**Green**
40-99%	**Amber**
< 40%	**Red**

ANNEXURE 59:

Checklist for sanitary and health care waste disposal bins

Use the checklist below to check whether there are sanitary and health care waste disposal bins and whether they have lids, are in good condition and are appropriately lined

Scoring – in column for score mark as follows:

Randomly select two toilets and two consulting rooms

Y (Yes) = available/with lid/appropriately lined, **N** (No) = not available/no lid/not appropriately lined, **NA** (Not applicable) = if the facility has less than the indicated areas

Item	Scores			
	Toilet 1	Toilet 2	Consulting room 1	Consulting room 2
Sanitary disposal bins with functional lids				
Sanitary disposal bins lined with red colour plastic bags				
Health care waste disposal bins with functional lids				
Health are waste disposal bins lined with red colour plastic bags				
Total score for all toilets and consulting rooms				
Total maximum possible score (sum of all toilets and consulting rooms minus the ones marked NA)				
Percentage (Total score ÷ Total maximum possible score) x 100				%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 60:

Checklist for general disposal bins

Use the checklist below to check whether there are general disposal bins and whether they are appropriately lined with lids

Scoring – in column for score mark as follows:

Randomly select three consulting rooms to review

Y (Yes) = available/with lid/appropriately lined, **N** (No) = not available/no lid/not appropriately lined, **NA** (Not applicable) = if the facility has less than the indicated areas

Item	Scores		
	Service area 1	Service area 2	Service area 3
General disposal bins with functional lids			
Lined with transparent or black plastic bags			
Score			
Maximum possible score (sum of all scores minus the ones marked NA)			
Total score for all 3 service areas			
Total maximum possible score (sum of all 3 areas minus the ones marked NA)			
Percentage (Total score ÷ Total maximum possible score) x 100			%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 61:

Checklist for clean, intact and functional toilets

Use the checklist below to check whether the toilets are functional

Scoring – in column for score mark as follows:

Randomly select three toilets to review

Y (Yes) = intact, **N** (No) = not intact, **NA** (Not applicable) = if the facility has less than three toilets

Item	Score – Toilet 1	Score – Toilet 2	Score – Toilet 3
Cleanliness of toilets			
Windows clean			
Window sills clean			
Floor is clean			
Basins clean			
Mirrors are clean			
Toilets/urinals clean			
Sanitary bins clean and not over flowing			
The areas are odour-free			
All areas free of cobwebs			
Intact and functional			
The toilet bowl seat and cover/squat pan are intact			
The toilet bowl is stain free			
The toilet flush/sensor flush is functional			
The toilet cistern cover is complete and in place			
The urinals are intact and functional			
The urinal/flush sensor is functional			
Score			
Maximum possible score (sum of all scores minus the ones marked NA)			
Total score for all 3 toilets			
Total maximum possible score (sum of all 3 toilets minus the ones marked NA)			
Percentage (Total score ÷ Total maximum possible score) x 100			%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 62:

Checklist for exterior areas

Use the checklist below to check whether the exterior of the facility is aesthetically pleasing and clean

Scoring – in column for score mark as follows:

Observe the general exterior environment of the facility

Y (Yes) = adheres to prompt, **N** (No) = does not adhere to prompt, **NA** (Not applicable) = if the facility's structural make-up does not allow for gardens, e.g. in a multi-story building in a city, at least one prompt must be scored, e.g. "There is no dirt and litter around the facility's premises"

Prompts	Score
The facility's premises are clean (e.g. free from dirt and litter)	
Exterior walls of the facility are clean	
Corridors are clean	
Grass is cut	
Paving is free of weeds	
Flower beds are well kept and free of weeds	
Total score	
Total maximum possible score (sum of all scores minus the ones marked NA)	
Percentage (Total score ÷ Total maximum possible score) x 100	%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
90%	Green
40-89%	Amber
< 40%	Red

ANNEXURE 63:

Standard Operating Procedure for waste management

In terms of the National Department of Health's draft regulations

(1) All health establishments that generate health care waste shall:

(a) have a duty of care to dispose of the waste safely in terms of the National Environmental Management Act, 1998 (Act No. 107 of 1998) as amended;

(b) be legally and financially responsible for the safe handling and environmentally sound disposal of the waste they produce in terms of the polluter pays principle;

(c) be precautious by always assuming that the waste is hazardous until shown to be safe;

(d) have a cradle to grave responsibility of the waste from the point of generation until its final treatment and disposal; and

(e) minimise, re-use, recycle and recover health care general waste in terms of the National Waste Management Strategy, 2011 and any amendments thereof.

(2) Each minor and major generator of a health establishment shall take all reasonable measures to ensure that:

(a) once health care risk waste is placed in a healthcare risk waste container, the health care risk waste is not removed from that container for the purposes of decanting it into another container; sorting it or; any other purpose; until such health care risk waste is received by the licensed waste treatment or disposal facility;

(b) re-usable containers are effectively cleaned and disinfected before reuse;

(c) all persons who manually handle containers of untreated health care risk waste are provided and required to wear clean, protective gloves and overalls, changeable laboratory coats or other appropriate personal protective equipment;

(d) all medical and non-medical staff shall be immunised for hepatitis and other transmittable diseases prior to handling the waste; and

(e) the necessary equipment to deal with spillages and emergency incidents are readily available and conform to the requirements as stipulated in the Occupational Health and Safety Act, 1993 (Act No. 85 of 1993) as amended.

(3) All major and minor generators of a health establishment shall:

(a) identify and classify all healthcare risk waste generated in accordance with the provisions of SANS 10248-1:2008: *Management of health care waste – Part 1: Management of health care risk waste from a health care facility and SANS 10229-1:2010: Transport of dangerous goods – Packaging and large packaging for road and rail transport, Part 1: Packaging;* ***and the Waste Classification and Management Regulations, 2013 and any amendments thereof***.

(b) identify and classify all healthcare risk waste transported in accordance with the provisions of SANS 10228:2012: *The identification and classification of dangerous goods for transport by road and rail modes*;

(c) train employees on an ongoing basis in the correct identification and classification of health care waste; and

(d) keep records of all training.

(4) All major and minor generators of a health establishment shall:

(a) segregate all health care waste generated at the point of generation and containerise it to minimise the risk of contamination or pollution to human health and the environment;

(b) take reasonably practicable measures to minimise the volume of healthcare waste at source;

(c) separate health care general waste from health care risk waste;

(d) train employees on an ongoing basis in the correct segregation and minimisation of health care waste; and

(e) keep records of all training.

(5) All major and minor generators of a health establishment shall ensure that:

(a) all health care risk waste to be transported be packaged and labeled in accordance with the provisions of SANS 10229-1:2010: *Transport of dangerous goods Packaging and large packaging for road and rail transport, Part 1: Packaging, SANS 452:2008: Non-reusable and reusable sharps containers* ***and Waste Classification and Management Regulations, 2013 and any amendments thereof***;

(b) all healthcare risk and health care general waste generated be packaged and labelled in accordance with the provisions of SANS 10248-1:2008: *Management of health care waste – Part 1: Management of health care risk waste from a healthcare facility;* ***and Waste Classification and Management Regulations, 2013 and any amendments thereof***.

(6) All major and minor generators of a health establishment shall ensure that:

(a) all health care risk waste be stored in accordance with the provisions of the ***Norms and Standards for Storage, 2013 under the Waste Act***;

(b) all major generators of a health establishment must have dedicated intermediate and central storage areas for health care risk waste storage.

(c) all minor generators of a health establishment shall designate appropriate intermediate or central storage areas for health care risk waste.

(d) all health care general waste shall be stored in refuse receptacles as stipulated in the provisions of the National Domestic Waste Collection Standards, 2011 and any amendments thereof, under the Waste Act.

(7) (i) All major and minor generators of a health establishment shall ensure that the collection and transportation of healthcare waste on and off site be in accordance with the provisions in the SANS 10248-1:2008: *Management of healthcare waste – Part 1: Management of healthcare risk waste from a healthcare facility*; and the National Domestic Waste Collection Standards, 2011 and any amendments thereof, under the Waste Act;

(ii) ***All major generators of a health establishment shall ensure that all healthcare risk waste be weighed on site prior to collection at all times***.

(iii) ***All minors generators of a health establishment shall ensure that all health care risk waste be weighed at all times***.

(iv) All vehicles used for health care risk waste collection and transportation must:

(a) conform to the requirements of the National Road Traffic Act, 1996 (Act No. 93 of 1996); SANS 10232-1:2007: *Transport of dangerous goods – Emergency information systems; Part 1: Emergency information system for road transport*; SANS 10231:2010: *Transport of dangerous*

goods – Operational requirements for road vehicles; SANS10229-1:2010: *Transport of dangerous goods– Packaging and large packaging for road and rail transport, Part 1: Packaging* and SANS 10228:2012: *The identification and classification of dangerous goods for transport by road and rail modes* and any amendments thereof.

(8) (a) All major and minor generators of a health establishment shall ensure that the on and off site waste treatment and disposal facilities for health care risk waste shall conform to ***all relevant legislation***.

(b) The waste treatment facilities, combustion technologies, that treat health care risk waste in operation, must have a valid atmospheric emission license and ***waste management license*** in place ***in terms of the Air Quality Act and Waste Act respectively***.

(c) The waste treatment facilities, non-combustion technologies, that treat health care risk waste and waste disposal facilities in operation, must have a valid waste management license in place ***in terms of the Waste Act***.

(d) The ***waste*** residues generated from health care risk waste treatment facilities' combustion and ***non-combustion technologies must be disposed off in terms of the relevant norms and standards under the Waste Act***.

ANNEXURE 64:

Checklist for standard security guard room

Use the checklist below to check whether the security guard room adheres to standard guidelines

Scoring – in column for score mark as follows:

Y (Yes) = adheres to prompt, **N** (No) = does not adhere to prompt, **NA** (Not applicable) = if the facility's structural make-up does not allow for a security guard room, e.g. in a multi-story building in a city or very small facilities. Security services should however still be available, therefore measures listed under equipment and stationery must be scored

Item	Score
Security guard room	
Gun safe	
Toilet with hand wash basin	
Kitchenette – sink with cupboard underneath	
Table	
Chair	
Functioning lights	
Security equipment for security officer(s) and accompanying stationery	
Pepper spray	
Baton	
Handcuffs	
Incident book	
Metal detector	
Whistle	
Telephone / two-way radio	
Total score	
Total maximum possible score (sum of all scores minus the ones marked NA)	
Percentage (Total score ÷ Total maximum possible score) x 100	%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
100%	Green
41-99%	Amber
< 40%	Red

ANNEXURE 65:

Checklist for firefighting equipment

Use the checklist below to check whether fire-fighting equipment is available

Scoring – in column for score mark as follows:

Y (Yes) = available/intact, **N** (No) = not available intact

Item	Score
Fire extinguishers	
Fire hoses	
Fire hose reels	
Record shows that equipment has been serviced within the last year	
Total score	
Percentage (Total score ÷ 4) x 100	%

Score calculation: Y = 1 N = 0

Percentage obtained	Score
100%	Green
41-99%	Amber
< 40%	Red

ANNEXURE 66:

Control sheet for inspection of fire fighting equipment

Faciliy name: ..... **Date inspected:** .....

Type of fire fighting equipment	Location	Date of last service	Date of next service	Condition of equipment

ANNEXURE 67:

Evacuation drill report

Date of evacuation drill	Staff member responsible for arranging and conducting drill	Findings of evacuation drill (shortfalls)	Corrective action taken	Date of repeating drill to establish if shortfalls were corrected

ANNEXURE 68:

Checklist for facility's space to accommodate all services

Use the checklist below to check whether the various internal and external areas are maintained

Scoring – in column for score mark as follows:

Check whether the following areas are present and sufficient

Y (Yes) = available, **N** (No) = not available, **NA** (Not applicable) = for small facilities that cannot accommodate all the areas due to the size of the facility

Item	Score
Interior space	
General	
Main waiting area	
Help desk/Reception/patient registration	
Toilets	
Clinical Service Areas	
Sub-waiting area	
Vitals area /room	
Consulting room	
Counselling room	
Emergency/resuscitation room	
Health Support services (Allied health)	
Treatment room	
Support /administration areas	
Boardroom /meeting room	
Facility manager office	
Kitchen	
Staff tea room	
Medicine store room /dispensary/Pharmacy	
• Shelves available	
Medicine collection kiosk (CCMDD)	
Surgical stores store-room	
Cleaning material store room	
Laundry	
Dirty utility room	
Linen room	

Exterior space	
Parking spaces	
a. Staff	
b. Disabled	
c. Ambulance	
Waste storage room	
a. Domestic/general area	
b. Medical/bio-hazardous area	
c. Access controlled room (free from rodents, scavengers, rain, and no unauthorised people)	
Garden store room	
Drying area (for mops, etc.)	
Total score	
Total maximum possible score (sum of all scores minus the ones marked NA)	
Percentage (Total score ÷ Total maximum possible score) x 100	%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
100%	Green
41-99%	Amber
< 40%	Red

ANNEXURE 69:

Checklist for maintenance of facility's infrastructure

Use the checklist below to check whether the various internal and external areas are in good condition

Scoring – in column for score mark as follows:

Randomly select the number of areas to review as indicated in the column for scores

Y (Yes) = adheres to prompt, **N** (No) = does not adhere to prompt, **NA** (Not applicable) = if the facility has less than the indicated areas or if prompt is not applicable to the specific facility because of the structural make-up of the facility, e.g. in a multi story building in a city

Area and prompts	**Scores**	
Exterior of building(s)		
Walls – paint in good condition		
Roof intact		
Gutters:		
a. Intact		
b. Paint in good condition		
Doors and gates:		
a. Working condition		
b. Handles working		
c. Can open and close		
Lights:		
a. Present		
b. Functioning		
Paving is intact		
Score for exterior of building(s)		
Maximum possible score for exterior of building(s) (sum of all scores minus the ones marked NA)		
Percentage for exterior of building(s) (Score ÷ Maximum possible score) x 100		%
Interior of building(s)		
Waiting areas	Waiting area 1	Waiting area 2
Walls – paint in good condition		
Ceiling:		
a. Paint in good condition		
b. Intact		
Lights:		
a. Present		
b. Functioning		

Windows:		
a. Window panes intact (glass not broken)		
b. Handles working		
c. Windows can open and close		
Score for waiting areas		
Maximum possible score for waiting areas (sum of all scores minus the ones marked NA)		
Percentage for waiting areas (Score ÷ Maximum possible score) x 100		%
Ablution facilities	Ablution 1	Ablution 2
Wall mounted paper towel dispenser(s)		
Wall mounted hand soap dispenser(s)		
Wall tiles in good condition		
Walls - paint in good condition		
Ceiling:		
a. Paint in good condition		
b. Intact		
Lights:		
a. Present		
b. Functioning		
Windows:		
a. Window panes intact (glass not broken)		
b. Handles working		
c. Windows can open and close		
Doors:		
a. Intact		
b. Handles working		
c. Can open and close		
Hand wash basins:		
a. Intact		
b. Taps functional (with running water)		
Floor intact		
Score for ablution facilities		
Maximum possible score for ablution facilities (sum of all scores minus the ones marked NA)		
Percentage for ablution facilities (Score ÷ Maximum possible score) x 100		%
Consultation rooms	Consultation room 1	Consultation room 2
Wall mounted paper towel dispenser(s)		
Wall mounted hand soap dispenser(s)		

Walls – paint in good condition		
Floor in good condition		
Ceiling:		
a. paint in good condition		
b. Intact		
Lights:		
a. Present		
b. Functioning		
Windows:		
a. Window panes intact (glass not broken)		
b. Handles working		
c. Windows can open and close		
d. Window covering (curtains/blinds)		
Doors:		
a. Intact		
b. Handles working		
c. Can open and close		
Hand wash basins:		
a. Intact		
b. Taps functional (with running water)		
Score for consultation rooms		
Maximum possible score for consultation rooms (sum of all scores minus the ones marked NA)		
Percentage for consultation rooms (Score ÷ Maximum possible score) x 100		%
Vital signs rooms	Vital signs room 1	Vital signs room 2
Wall mounted paper towel dispenser(s)		
Wall mounted hand soap dispenser(s)		
Walls – paint in good condition		
Floor intact		
Ceiling:		
a. Paint in good condition (not peeling/faded)		
b. Intact (not broken)		
Lights:		
a. Present		
b. Functioning		
Windows:		
a. Glass not broken		

b. Handles working		
c. Windows can open and close		
Doors:		
a. Intact		
b. Handles working		
c. Can open and close		
Hand wash basins		
a. Intact		
b. Taps functional		
Score for vital signs rooms		
Maximum possible score for vital signs rooms (sum of all scores minus the ones marked NA)		
Percentage for vital signs rooms (Score ÷ Maximum possible score) x 100		%

Summary for all areas

Area	Score	Maximum possible score
Exterior of building(s)		
Interior of building(s)		
Waiting areas		
Ablution facilities		
Consultation rooms		
Vital signs rooms		
Total score/Total maximum possible score		
Percentage (Total score ÷ Total maximum possible score) x 100		%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
80%	Green
40-79%	Amber
< 40%	Red

ANNEXURE 70:

Record to track maintenance work

Maintenance/ works order number	Date maintenance requested	Name and surname of staff member that requested the maintenance	Short description of maintenance requested	Notes on dates on which follow-ups were made	Date maintenance carried out and finalised

ANNEXURE 71:

Checklist for furniture in service areas

Use the checklist below to check whether consulting rooms have sufficient furniture

Scoring – in column for score mark as follows:

Randomly select the number of areas to review as indicated in the column for scores

Y (Yes) = available/intact, **N** (No) = not available/not intact, **NA** (Not applicable) = if the facility has less than the indicated areas

Item	**Scores**	
Waiting areas	**Waiting area 1**	**Waiting area 2**
Seating		
a. Adequate seating for all patients		
b. Chairs/benches intact		
Notice boards available		
Score for waiting areas		
Maximum possible score for waiting areas (sum of all scores minus the ones marked NA)		
Consultation rooms	**Consultation room 1**	**Consultation room 2**
Desk		
a. Available		
b. Intact (including the drawers)		
Chair (clinician)		
a. Available		
b. Intact		
2 x chairs (patients)		
a. Available		
b. Intact		
Examination couch /2 part obstetric tilting		
a. Available		
b. Intact		
Bedside footstool – 2 steps		
a. Available		
b. Intact		
Wall mounted or portable angle poise examination lamp		
a. Available		
b. Intact		

Lockable medicine cupboards		
a. Available		
b. Intact		
Dressing trolley (at bedside for examination equipment)		
a. Available		
b. Intact (including the drawers)		
Wall mounted mirror above wash hand basin		
a. Available		
b. Intact		
Score for consultation rooms		
Maximum possible score for consultation rooms (sum of all scores minus the ones marked NA)		
Total score for waiting areas and consulting rooms		
Total maximum possible score (sum of all waiting areas and consulting rooms minus the ones marked NA)		
Percentage (Total score ÷ Total maximum possible score) x 100		%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
90%	Green
40-89%	Amber
< 40%	Red

ANNEXURE 72:

Checklist for essential equipment in consulting areas

Use the checklist below to check whether essential equipment is available in consultation/vital and child health rooms

Scoring – in column for score mark as follows:

Randomly select the number of areas to review as indicated in the column for score

Y (Yes) = available, **N** (No) = not available, **NA** (Not applicable) = if the facility has less than the indicated areas

Item	Consultation room 1	Consultation room 2	Vital signs room	Child health room
Consultation rooms				
Stethoscope				
Blood glucometer				
Non-invasive Baumanometer (wall mounted/portable)				
Adult, paediatrics and large cuffs (3) for Baumanometer				
Diagnostic sets – including ophthalmic pieces(wall mounted or portable)				
Patella hammer				
Tuning fork (only required in one consultation room)				
Penlight torch with spare batteries				
Tape measure				
Clinical thermometers				
Score for consultation rooms				
Maximum possible score for consultation rooms (sum of all scores minus the ones marked NA)				
Percentage for for consultation rooms (Score ÷ Maximum possible score) x 100				%
Vital signs room				
Non-invasive electronic Baumanometer (wall mounted/portable)				
Adult, paediatrics and large cuffs (3) for Baumanometer				
Blood glucometer				
Adult clinical scale up to 150 kg				
Stethoscope				
HB meter				
Clinical thermometer				
Height measure				
Tape measure				
Bin (general waste)				
Urine specimen jars				

Score for vital signs room				
Maximum possible score for vital signs room (sum of all scores minus the ones marked NA)				
Percentage for for vital signs room (Score ÷ Maximum possible score) x 100				%
Child health room				
Baby scale				
Bassinet				
Stethoscope				
Blood glucometer				
Non-invasive Baumanometer (wall mounted/portable)				
Adult, paediatrics and large cuffs (3) for Baumanometer				
Diagnostic sets – including ophthalmic pieces (wall mounted or portable)				
Patella hammer				
Penlight torch with spare batteries				
Tape measure				
Clinical thermometers				
Score for child health room				
Maximum possible score for child health room (sum of all scores minus the ones marked NA)				
Percentage for child health room (Score ÷ Maximum possible score) x 100				%

Summary for all rooms

Area	Score	Maximum possible score
Consultation rooms		
Vital signs room		
Child health room		
Total score/Total maximum possible score		
Percentage (Total score ÷ Total maximum possible score) x 100		%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 73:

Checklist for resuscitation room

Use the checklist below to check whether the emergency/resuscitation room is equipped with functional basic equipment

Scoring – in column for score mark as follows:

Check the room where resuscitation is done

Y (Yes) = available, **N** (No) = not available

Item	Score
Emergency trolley with lockable medicine drawer and accessories	
Examination couch/2 part obstetric delivery bed	
Nebuliser OR face mask with nebuliser chamber for adult and paediatric	
Functional electric powered OR manual suction devices and suction catheters	
Drip stand	
Height adjustable stool, with or without backrest	
Haemoglobin meter	
Dressing trolley	
Cardiac arrest board	
Bin (general waste)	
Suture material	
Kick about with bucket	
Thermal (space) blanket	
Gloves exam n/sterile Gloves: small, medium and large at least one pair of each size	
Gloves surgical sterile latex: 6.5, 7, 7.5 and 8 at least one pair of each size	
Protective face shields	
Disposable plastic aprons	
Disposable non sterile face masks	
Resuscitation Algorithms	
Resuscitation documentation register	
Wall mounted liquid hand soap dispenser	
Wall mounted hand paper dispenser	
Total score	
Percentage (Total score ÷ 22) x 100	%

Score calculation: Y = 1 N = 0

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 74:

Checklist for emergency trolley

Use the checklist below to check whether the emergency trolley is sufficiently stocked

Scoring – in column for score mark as follows:

Check if the equipment and medication is available on the emergency trolley. Also ***check expiry date of medication. If medication are expired mark as 'N'***

Y (Yes) = available/functional, **N** (No) = not available/not functional

Item	Score
Laryngoscope handle with functional batteries	
Adult curved blades for laryngoscope sizes 1 to 4	
Paediatric straight blades for laryngoscope sizes 0 to 1	
Spare bulbs for Laryngoscope	
Spare batteries for Laryngoscope	
Endotracheal tubes - uncuffed sizes 2.5, 3.5 and 4.5mm	
Endotracheal tubes - cuffed sizes 5.0, 6.0, 6.5, 7.0, 7.5 and 8.0mm	
Penlight torch with spare batteries	
Water-soluble lubricant / lubricating jelly	
Tape or equivalent to hold tie endotracheal tube in place	
Patellar hammer	
Oropharyngeal airways (Guedel) size 0, 1, 2 3, 4 and 5	
Introducers for endotracheal tubes OR bougie with adult stylets	
Introducers for endotracheal tubes OR bougie with paediatric stylets	
Magill's forceps for adults	
Magill's forceps for paediatric	
Laryngeal masks (supraglottic airways): Neonate/infant, paediatric and adult	
Manual bag valve mask/ manual resuscitator OR self inflating bag with compatible masks for adults	
Manual bag valve mask/ manual resuscitator OR self inflating bag with compatible masks for paediatric	
Simple face mask OR reservoir mask OR nasal cannula (prongs) for oxygen, adults	
Simple face mask OR reservoir mask OR nasal cannula (prongs) for oxygen, paediatric	
Face mask for nebuliser OR face mask with nebuliser chamber for adult	
Face mask for nebuliser OR face mask with nebuliser chamber for paediatric	
Automatic External Defibrillator (AED) OR ECG monitor and defibrillator	
I.V. cannulae: 14, 18 and 20G and appropriate strapping	
Syringes:5ml; 10 or 20ml & Insulin syringes	
Needles 3 sizes: Size 18 (pink) OR 20 (yellow), 21 (green), 23 (Blue) OR 24 (Black)	

Sharps container	
Admin set 20 drops/ml 1.8m /pack	
Admin set paeds 60 drops/ml 1.8m /pack	
Stethoscope	
Blood glucose testing machine, strips and spare batteries	
Diagnostic Set and batteries including opthalmic pieces(wall mounted or portable)	
Rescue scissors (to cut clothing)	
Paediatric Broselow tape	
Wound care (Gauze, bandages, cotton wools, plasters, alcohol swabs and antiseptic solutions)	
Urinary (Foley's) catheters: 10f, 14f and 18f at least one of each size and bags specified in the surgical supply list	
Nasogastric tubes: 600mmfg5, 600mmfg8 and 1000mmfg10 at least one of each size	
Medication/vaculitre stickers	
Present individually or in combined multifunctional diagnostic monitoring set	
Pulse oximeter with adult & paediatric probes	
Non invasive electronic blood pressure monitoring device including paediatric & large adult cuff sizes	
Clinical thermometer (in 0C, non-mercury)	
Emergency medicines (also check expiry dates)	
Activated Charcoal	
Adrenaline Injection 1mg/ml (Epinephrine)	
Amlodipine 5mg OR 10mg tablets	
Antihistamine e.g. promethazine 25mg injection	
Aspirin tablets	
Atropine 0.5mg OR 1mg injection	
Benzodiazepine e.g. diazepam tablets OR injection	
Calcium gluconate 10% injection	
Furosemide 20mg ampoule	
Hydrocortisone 100mg injection	
Insulin, short acting	
Ipratropium 0.25mg/2ml OR 0.5mg/2ml Unit dose vial for nebulisation	
Lidocaine/Lignocaine IV 1% OR 2% ampoules	
Magnesium sulphate 50%, 2ml ampoule	
Nifedipine 5mg OR 10mg capsules	
Short acting sublingual nitrates e.g. glycerol trinitrate SL	
Short acting β2 agonist solution e.g. Salbutamol	
Thiamine 100mg injection	
Water for Injection	

IV Solutions	
Dextrose 10% OR 50%	
Pediatric solutions e.g. ½ strength Darrows solution or neonatalyte solution	
Sodium Chloride 0.9%	
Total score	
Percentage (Total score ÷ 64) x 100	%

Score calculation: Y = 1 N = 0

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 75:

Checklist for sterile emergency delivery pack

Use the checklist below to check whether there is sterile emergency packs available

Scoring – in column for score mark as follows:

Y (Yes) = available, **N** (No) = not available, **NA** (Not applicable) = only for Extras (Non-negotiable must be present)

Note: sterile packs must be labeled with the contents of the pack

Item	Quantity	Score
Non-negotiable		
Multipurpose scissors	1	
Dissecting forcep non-toothed (plain)	1	
Dissecting forcep toothed	1	
Artery forceps straight long	2	
Needle holder	1	
Small bowl	2	
Kidney dishes OR receivers (big)	2	
Extras		
Basin	1	
Stainless steel round bowl large	1	
Green towels	4	
Disposable apron	2	
Abdominal swabs	2	
Gauzes	5	
Vaginal tampon	1	
Sanitary towels	2	
Round cotton wool balls	1 pack	
Umbilical cord clamps	2	
Total score		
Total maximum possible score (sum of all scores minus the ones marked NA)		
Percentage (Total score ÷ Total maximum possible score) x 100		%

Score calculation: Y = 1 N = 0 NA = NA

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 76:

Checklist for sterile packs for minor surgery

Use the checklist below to check whether equipment for minor surgery is available

Scoring – in column for score mark as follows:

Y (Yes) = available/functioning, **N** (No) = not available/functioning

Note: sterile packs for minor surgery must be labelled indicating the contents of the pack

Item	Quantity	Score
Minor stitch / suturing tray		
Small stitch tray	1	
Stitch scissor	1	
Toothed forcep	1	
Non-toothed forcep	1	
Blades – BP Handle size 4 or 5	5	
Mosquito straight	2	
Mosquito curved	2	
Artery forceps straight	2	
Artery forceps curved	2	
Needle holder	1	
Swab holder	1	
Mayo safety pin	1	
Gillies forcep	1	
Total score		
Percentage (Total score ÷ 13) x 100		%

Score calculation: Y = 1 N = 0

Percentage obtained	Score
100%	Green
40-99%	Amber
< 40%	Red

ANNEXURE 77:

Checklist for oxygen supply

Operational Plan			
Facility:		**Date from:**	**Date to:**
Day of the week	**Pressure gauge reading**	**Date checked**	**Signature**
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

ANNEXURE 78:

Asset disposal form

This form is to be completed if any equipment/furniture within the facility is to be disposed of. This form, once completed, must be sent to Supply Chain Management.

Region: ..... **Facility:** .....

Department: ..... **Date:** .....

List of equipment/furniture to be disposed						
	Asset number	Location	Description	Purchase date	Original cost	Disposal value
1						
2						
3						
4						
5						
6						
7						
8						

Reason for disposal:

.....

.....

.....

.....

.....

Method of disposal: (please tick)

Scrapped ☐

Auction ☐

Donated ☐

Authorised by: ..... **Date:** .....

ANNEXURE 79:

Schedule for meetings

Meeting schedule

Facility name: ..... **Month:** ..... **Year:** .....

Weekday	Date	Week 1	Date	Week 2	Date	Week 3	Date	Week 4
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								

ANNEXURE 80:

Template for agenda

Facility name: .....

Agenda for: .....

Date: .....

Venue: .....

Agenda points
1. Opening and welcome
2. Attendance and apologies
3. Finalisation of the agenda
4. Adoption of the previous meeting minutes
5. Matters arising from the previous meeting's minutes
6. Standing items
7. Additional matters
8. Date of next meeting
9. Closure

ANNEXURE 81:

Template for attendance register for meetings

Facility name: .....

Attendance register for: .....

Date: .....

Venue: .....

Name and surname	Rank	Contact number	Organisation / section	Signature

ANNEXURE 82:

Example of services and activities for an open day

Theme:	**Immunisation/Child Health**
Before the event:	Use health promoters to inform community about the event. Request community members to bring Road to Health Charts (RTHC).
MC:	Facility manager: Purpose of open day
Welcome speech:	Local Ward Counsellor
Opening speech:	MCWH coordinator: The importance of immunisation
MC:	Explain the activities offered
Activities:	Check RTHC Offer catch-up immunisation Screening height and weight Screening developmental milestones
Stations:	1. Screening 2. Immunisation 3. Facts and information about immunisation/ child health (with pamphlets) 4. Children's activities (colouring, face-painting, clowns, magicians)

ANNEXURE 83:

Register for ambulance turnaround times

Request date	Request time	Request clinician	Clinician signature	Patient name and surname	Patient number	Arrival date	Arrival time	Name of responding officer	Signature of responding officer	Actual turnaround time

ANNEXURE 84:

Referral pathways

The referral pattern in districts are as follows:

1. Vertical referral

- vertical referral, i.e. patient referral from a lower to a higher level of healthcare facility, either in the same district or another district, and vice versa, based on the role and responsibilities of each category of healthcare facility.
- School Health Teams and the Nurse Team Leader of the ward-based PHC Outreach Teams refer relevant cases to the PHC facility or to the Level 1 hospital in the catchment area.
- PHC clinics refer all cases that cannot be managed at PHC level to the Level 1 hospital in the catchment area, according to clinical guidelines.
- oral health outreach services refer cases for advanced oral health services to the fixed clinics. For example severe maxilla-facial and orthodontic cases are referred to Tertiary Hospital in the relevant province.
- Level 1 hospitals refer patients in need of specialist healthcare to the Level 2 hospital in the catchment area.
- when there is a justifiable reason for deviation from the standard referral pattern, a Level 1 hospital may bypass the standard route of referral and send the patient directly to the Level 3 hospital. The Head of Clinical Services of the Level 2 hospital must give clearance for a Level 1 hospital to bypass the standard referral route and send a patient directly to the Level 3 hospital.
- Level 2 hospitals refer patients in need of specialist healthcare to the appropriate tertiary facility.

All referred patients at all levels are to be referred back from the referral facility to the referring facility.

2. Horizontal referral

- horizontal referral, i.e. patient referral to a healthcare setting with similar scope and healthcare service package, for continuity of care, either in the same district or another district.
- patients are referred from one PHC facility to another, e.g. referral of a patient who receives monthly medication for a chronic condition at a PHC facility, who relocates to another area in the same sub-district or another sub-district within the district or another district.
- a patient can be referred from one ward-based PHC setting to another, e.g. a patient on ARVs who relocates from one ward to another within the district can be referred by the Ward-based PHC Outreach Team leader to the care of the Ward-based PHC Outreach Team operating in the ward into which the patient will be relocating.

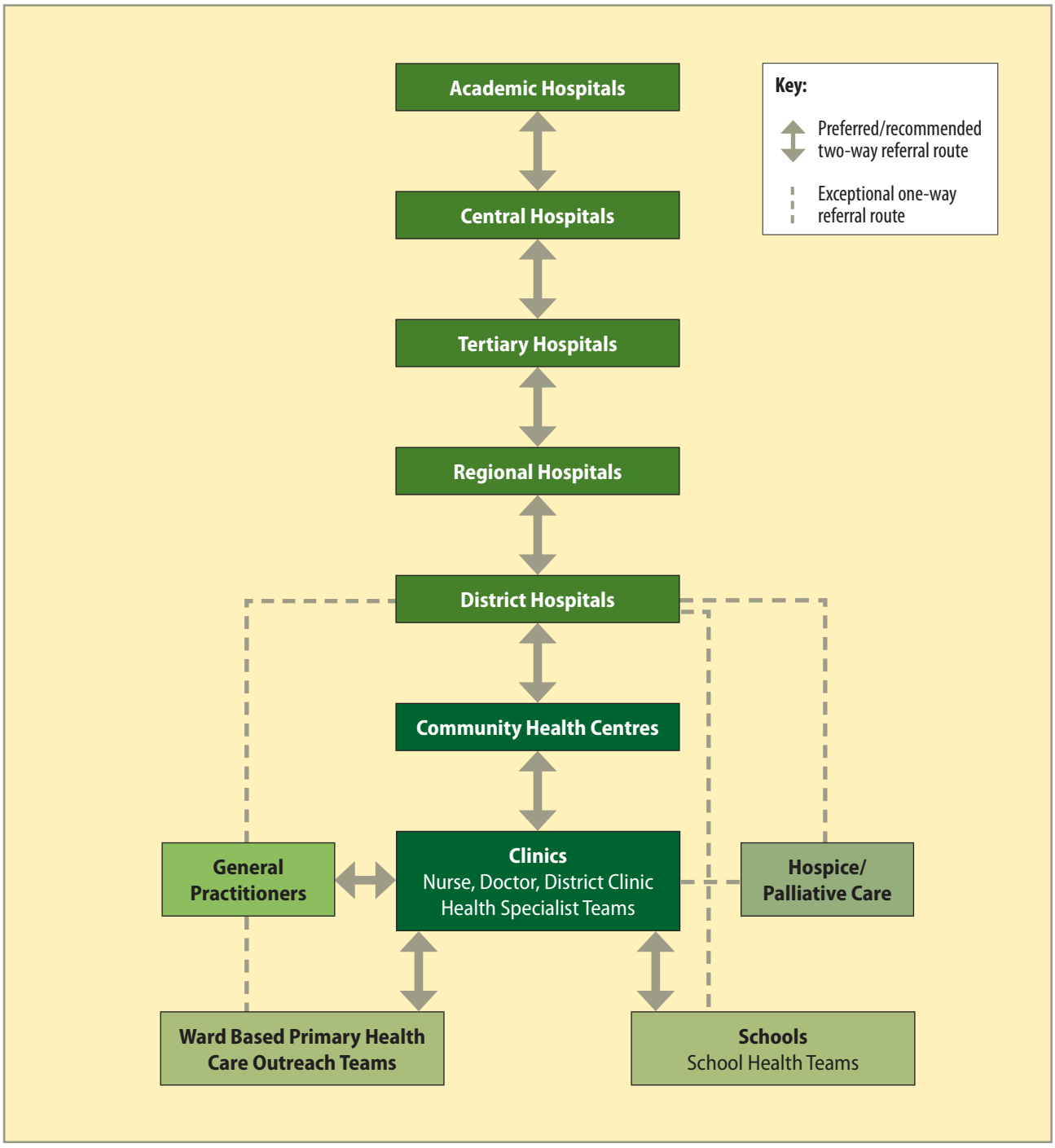
3. Downward referral

- Patients who entered a certain level of care without referral, who require a lower level of care after initial assessment, or who are in need of continuity of care, follow-up and rehabilitation are down-referred to the appropriate level of care.
- Patients are referred from a PHC facility to the ward-based CHW for services rendered at their level, e.g. a TB patient on clinic-based DOTS can be referred to community-based DOTS by the CHW under the supervision of the nurse team leader.

4. Inter-sectoral referral

- patients are also referred to and from other organisations and government departments which render services that are beyond the scope of the district healthcare service. These entities refer clients in need of healthcare to PHC facilities where they will be managed accordingly, e. g. Department of Social Development may refer a baby, who has not been immunised and whom they have detected during their course of work, to the PHC facility in the catchment area for immunisation.
- referrals from private healthcare practitioners. Private healthcare practitioners refer patients who require healthcare services at PHC level or a higher level of healthcare, and who are not financially capable to pay for private healthcare services, to a public healthcare facility where they will be treated according to public health policies.

Flow diagram of referral pathways



ANNEXURE 85:

General Primary Health Care referral and feedback form

health Department: Health REPUBLIC OF SOUTH AFRICA	**General PHC patient referral form** *A patient has been referred to your facility/service by the Primary Health Care facility as indicated below. Thank you for seeing this patient, we look forward to working together for improved health and welfare for all South Africans.*
REFERRED TO: Name of facility	
Department/doctor referred to (where applicable):	

Patient details			
Patient name and surname	Patient address		
	Date of Birth *(dd/mm/yyyy)*	Age	Gender
Patient contact telephone number			
Patient file/record number			

Clinical information on patient	
History	
Possible diagnosis	
Relevant past history	
Current medication and treatment given	
Vital data and examination	
Reason for referral	

REFERRED BY:	
Name of facility	
Contact details	
Name and surname of healthcare professional	
HPCSA/SANC NO	
Signature of healthcare professional	
Date	

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

General PHC patient referral feedback form

A patient has been referred to your service as indicated on the attached referral form. Please complete this form and give it to the patient so that he/she can bring it along with them at their next visit to the facility

FEEDBACK TO: Name of facility	
Name and surname of healthcare professional	

Patient details																			
Patient name and surname										Patient address									
										Date of Birth *(dd/mm/yyyy)*								Age	Gender
Patient contact telephone number																			
Patient file/record number																			

Clinical information on patient	
Examination	
Diagnosis	
Treatment (medication, referral ect.)	

FEEDBACK FROM:	
Name of facility	
Contact details	
Name and surname of healthcare professional	
HPCSA/SANC NO	
Signature of healthcare professional	
Date	

ANNEXURE 86:

Register for patient referrals

Name of facility: .....

Facility manager: ..... Contact number: .....

Date referred	Patient details (name and surname, file record number)	Referral destination	Reason for referral	Date feedback received	Feedback from referral destination

ANNEXURE 87:

Reporting template for implementing partners

Name of organisation:.....

Person reporting: .....

Date of meeting: .....

Objective 1:			
Activity	**Progress**	**Challenges**	**Mitigation actions**

Planned activities for next quarter:

.....

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NOTES

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