ICSM model

Health Service Re-organisation

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

ICSM implementation

PRE-IMPLEMENTATION PREPAREDNESS

- PRE-IMPLEMENTATION
  - BRIEFING OF STAFF
  - SELECTION OF START DATE
  - FACILITY ICSM TEAM
  - COMMUNITY AWARENESS
- DATA COLLECTION
  - FACILITY WALK THROUGH
  - FACILITY DATA COLLECTION
  - WAITING TIME SURVEY
  - HUMAN RESOURCE TRAINING AUDIT
- DATA ANALYSIS
  - NUMBER OF PATIENTS TO BE BOOKED DAILY
  - NUMBER OF CONSULTATION ROOMS PER STREAM
  - PROCESS FLOW
  - HUMAN RESOURCE TRAINING REQUIREMENTS
  - MANAGEMENT OF PATIENT RECORDS

HEALTH SERVICE RE-ORGANISATION

- ADMINISTRATIVE RE-ORGANISATION
  - CREATING A SAFE ENVIRONMENT
  - SIGNAGE (INTERNAL AND EXTERNAL)
  - SINGLE ADMINISTRATIVE POINT
  - MANAGEMENT OF APPOINTMENTS
- SERVICE RE-ORGANISATION
  - FOUR STREAMS OF CARE
  - APPOINTMENTS
  - FAST QUEUE
  - CCMDD OR PRE-DISPENSING
  - DOWN REFERRAL
- CLINICAL MANAGEMENT SUPPORT
  - CLINICAL GUIDELINES AND TOOLS
  - CLINCIAL STATIONERY & PATIENTS RECORDS
  - TRAINING OF STAFF
  - DR & DISTRICT CLINICAL SPECIALIST TEAM

STRENGTHENING INDIVIDUAL AND POPULATION HEALTH

- 'ASSISTED' SELF- MANAGEMENT
  - COLLABORATION WITH WARD BASED OUTREACH TEAM
  - HOUSEHOLD VISITS
  - ADHERENCE CLUBS AND SUPPORT GROUPS
- POPULATION HEALTH AWARENESS & SCREENING
  - HEALTH AWARENESS DAYS
  - UNIVERSAL TEST AND TREAT
  - INTEGRATED SCHOOL HEALTH TEAM
  - WARD BASED OUTREACH TEAMS

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

ICSM model components

HEALTH SERVICE RE-ORGANISATION

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

CLINICAL MANAGEMENT SUPPORT

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

'ASSISTED' SELF-MANAGEMENT

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

POPULATION HEALTH AWARENESS & SCREENING

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

HEALTH SYSTEM STRENGTHENING

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

Strengthening of support systems and structures outside the health facility

What is Health Service Re-organisation?

HEALTH SERVICE RE-ORGANISATION

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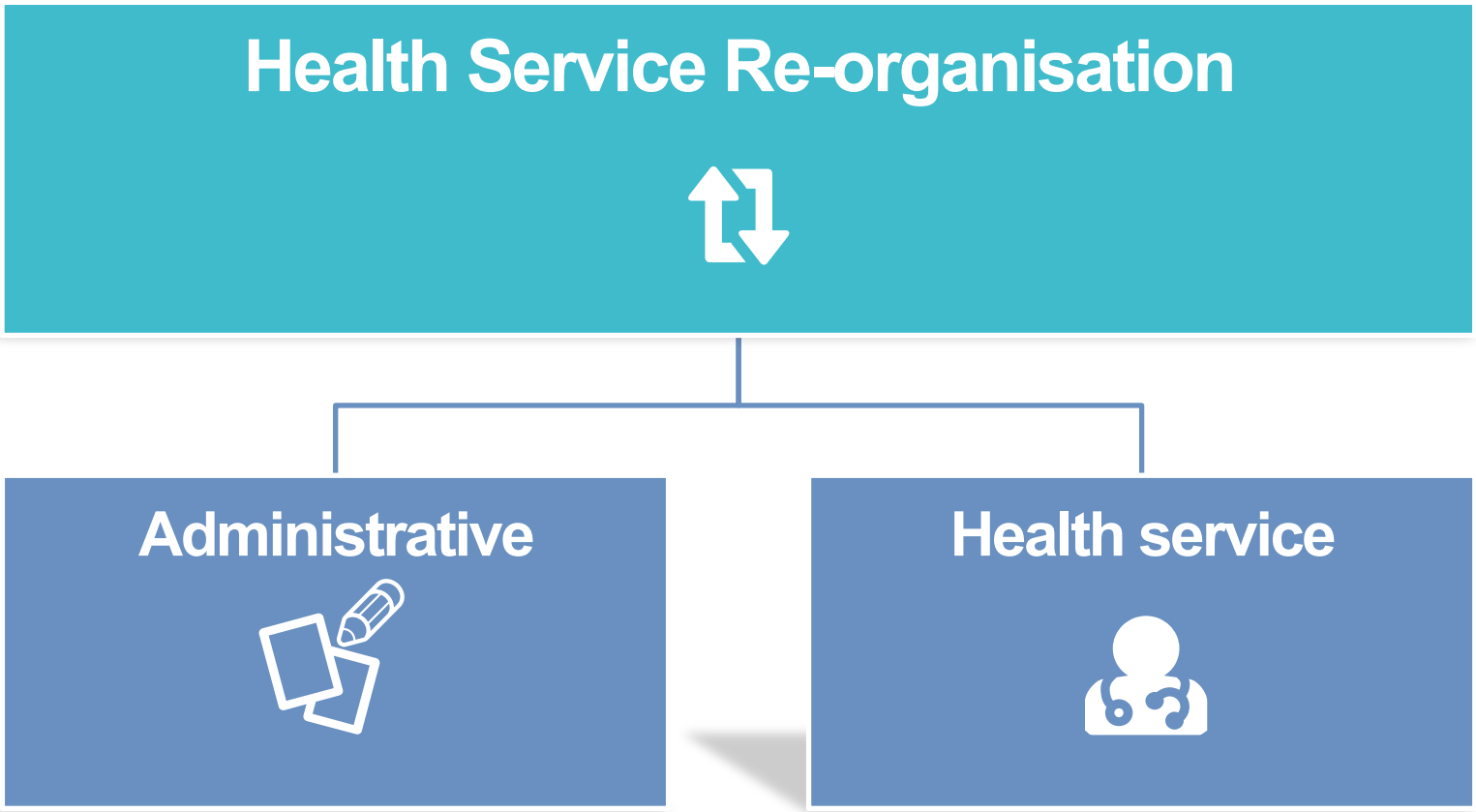
Health Service Re-organisation

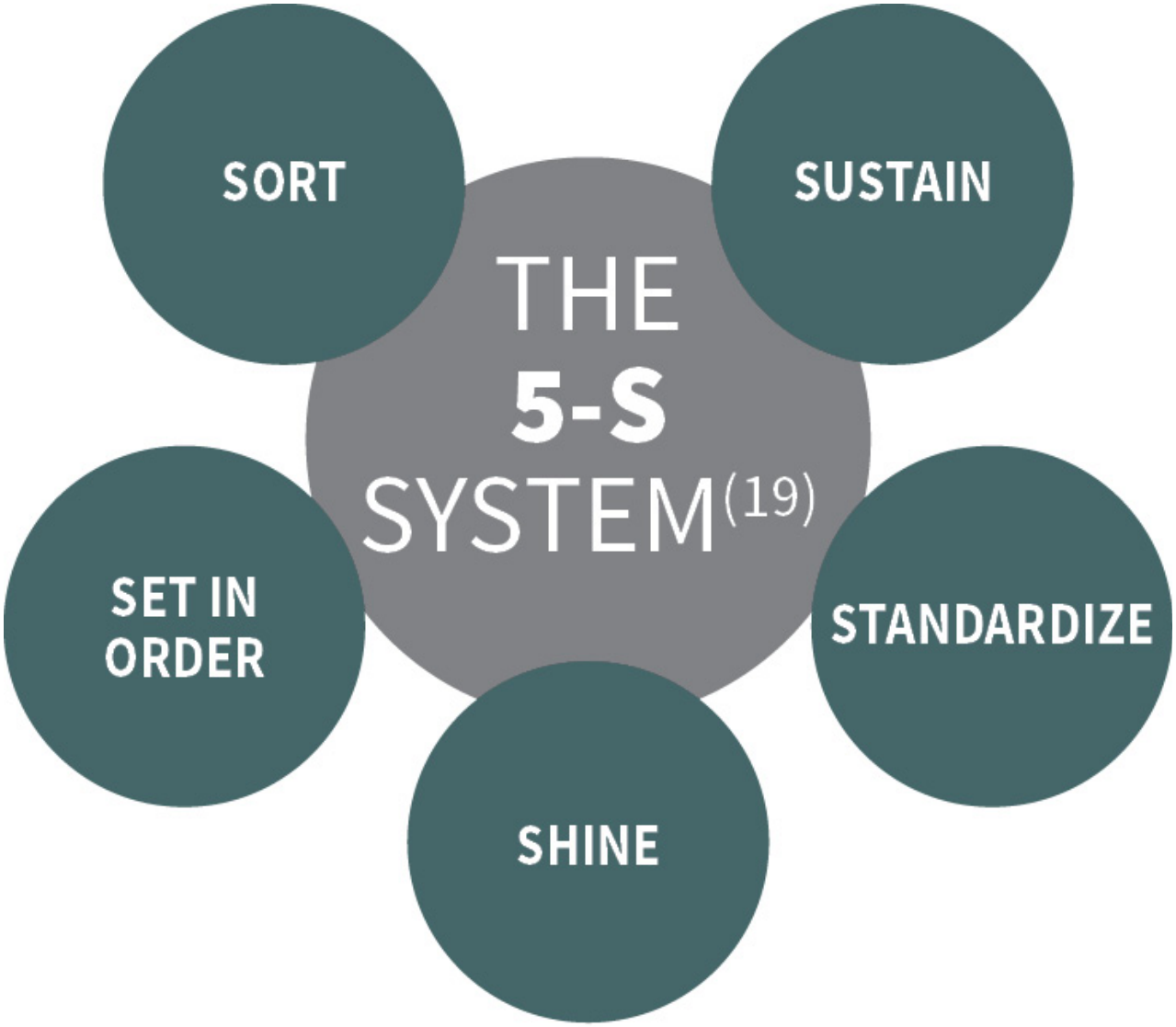


Administrative Re-organisation

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

- Creating a **safe environment**
- **Scheduling** of appointments
- **Pre-appointment retrieval** of clinical records including laboratory results
- **Pre-dispensing** of medication
- **Integration** of clinical records
- **Scheduling** of professional nurses

Creating a safe environment



Creating safe environment

SORT

'When in doubt, move it out!'

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

SET IN ORDER

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

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

Creating safe environment

SHINE

'Lean means clean'

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

STANDARDISE

S5

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

Creating safe environment

'Sustain all gains through self discipline'

Make 5S become a way of life by:

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

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

Single administrative point

- All patients record should be **triaged** at a single administrative point
- Patients records should be integrated and be available at the **single administrative point** for the patient
- **All new patients:** non-acute emergency patients should commence at the reception desk and be registered on the Health Patient Registration System South Africa (HPRS)

Single administrative point

- Chronic patients that are attending for a full consultation and **that have not been registered** on the HPRS should **commence at the reception desk** and be registered on the HPRS
- **Patients returning** to the facility for Directly Observed Treatment, Short Course (DOTS), scheduled appointments for family planning, immunisation, antenatal care and collection of chronic medication at the facility should **proceed directly to the dedicated chronic, MC&SRH or appointment vital signs station** of the various streams of care and receive their **pre-retrieved clinical record**

Single administrative point

- The patient can then be **registered on the HPRS** by the administration clerk after the visit has been completed or in a batch when the clinical record is returned to the reception area but on the **same day.**
- An alternative is that if the facility infrastructure and staffing levels allow, **multiple service points should be made available at the reception desk** that creates an aisle for scheduled and unscheduled patients.
- **Scheduled patients clinical records should already be pre-retrieved** and their entry on the HPRS should not be more than 20 seconds as claimed by the system implementers.
- These patients should then be **directed to the different streams of care.**

Integration of clinical records

- Each patient should have a **single file** across his or her life span
- The facility should have a **single system** for filing and storing patient's clinical records
- The records should not be stored per diagnostic condition but rather by the **patient surname, date of birth or address**

THE FILE NUMBER SHOULD CONTAIN

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

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

Should be rendered as:

1973/07/28MMA

Children clinical record

Once a female adolescent is pregnant an adult female record should be opened

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CHILDREN CLINICAL RECORD

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

Female clinical record

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FEMALE CLINICAL RECORD

Demographic details ..... Pg 2

Subsequent changes to demographics detail ..... pg 3

Patient profile – first visit .....pg 4-5

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ART initiation..... pg 10-11

Clinical management ..... pg 12 -25

Oral health care ..... pg 26-40

Rehabilitation service..... pg 41-47

Laboratory test results ..... pg 48-51

Prescription ..... pg 52-55

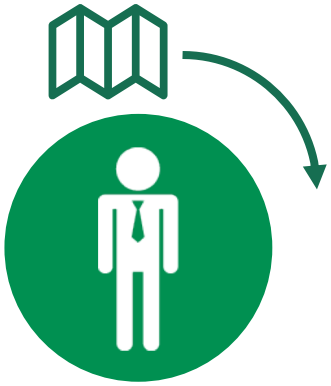
TB adherence..... pg 56-67

Consent for HIV and other testing..... pg 68-77

Consent for HIV and other testing..... pg 78-80

Pockets for laboratory results and referrals..... pg 81

Male clinical record



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ADULT MALE CLINICAL RECORD

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

Pre-appointment retrieval of patient records

- Between 48 and 72 hours prior to the patient's appointment the administrative clerk where available or support staff, should be provided with a copy of the **appointment schedule**
- The administrative clerk or support staff should retrieve the patient's record and **tick off in the scheduling book** after the record has been retrieved
- The professional nurse/administrative clerk should **retrieve any laboratory investigations results** for outstanding investigations conducted on previous visits and place the results in the records
- After updating the records, the records should be kept in a box at the reception, vital sign station or consulting room depending on facility arrangement

Appointment scheduling - responsibility

- If a **single room** is being utilised planned patients for the relevant services then the professional nurse in the **consulting room** should schedule the patient's next visit
- If more than one consulting room is being used, for the services and the facility is a fairly busy one then an appointment scheduling desk should be established **near the exit** of the facility
- An administrative clerk could be stationed in a **convenient area** and schedule the patients according to the information provided by the professional nurse

Determining the appointment date

- Depending on the patient's condition (immunisation, family planning, well-baby, post-natal care, antenatal care, and chronic care) and availability of medication at the facility **the patient will either return**:
  - *Based on clinical guidelines*
  - *Monthly basis if unstable or complicated patient*
  - *Every second or third month for a repeat prescription if patient is stable*
  - *After six months if the patient has been down referred to the PHC outreach team*
- The **maximum number of patients** that should be consulted daily is pre-determined
- At the beginning of each week, the professional nurses should determine and provide a **five-day period** on 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

Scheduling the appointment

The patients receiving an appointment will fall into various categories:

- Requiring a **full clinical examination** (six month visit) for stable chronic patients
- **Repeat visit** (chronic, immunisation, family planning, ANC)
- Consultation by **doctor**
- Collection of **medication-CCMDD** facility based

Adolescent and youth should be scheduled after school hours

Scheduling the appointment

- The format chosen to schedule patients will be facility **specific** - a time format should be used as this spreads the workload.
- In order to avoid the batching of patients and prolonging the waiting times, patients should be offered **time slots** for attending the appointment.
- Patients requiring six-month appointments should be **distributed equally across the time slots** or scheduled in a specific time slot to avoid prolonging the waiting times for other patients.

Frail, elderly and high risk clients will be given priority

The time slots should be per two-hour session with **ten patients scheduled per two-hour session**. At the end of each slot. Two to three slots should be left blank for patients that missed scheduled appointments but returned within the 96-hour grace period.

Scheduling the appointment

An appointment file or register needs to be completed using the format described below

Determining the appointment date

Department of health Patient Details | **Complete the consultation room number, day of the week and day**

Consultation room: 5 | Day of the week (circle): Mon Tues Wed Thur Fri Sat | Date: 01/11/2016

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

FIGURE 28: PATIENT SCHEDU NG TOOL)

Total number of patients attended: | Total number of missed appointments:

Total number of files - records retrieved: | Total number of files - records returned:

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

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

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

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

Complete patient's full name and surname

Indicate if the patient attended the appointment

At the end of the day indicate how many patients attended their appointments, missed their appointments, records retrieved and records returned

Separate appointment books for Chronic Care, MC&SRH, Health Support Services (if offered)

Single room single nurse clinic

HOW WILL AN APPOINTMENT SYSTEM WORK IN A SINGLE ROOM AND SINGLE NURSE CLINIC?

1. Chronic stable patients for medicines collection should be scheduled between 07h30 and 08h30 or between 15h00 and 16h00
2. Well baby clinic, immunisation, post-natal visits and follow up antenatal visits should be scheduled for the 1st 2 hours (8h30-10h30)
3. Patient with acute episodic illness, antenatal 1st visits and patients for chronic prescription 6 month review should be scheduled between 10h30 and 14h00
4. Family planning and other preventive services should be offered between 14h30 and 16h00
5. Emergencies should be consulted at anytime

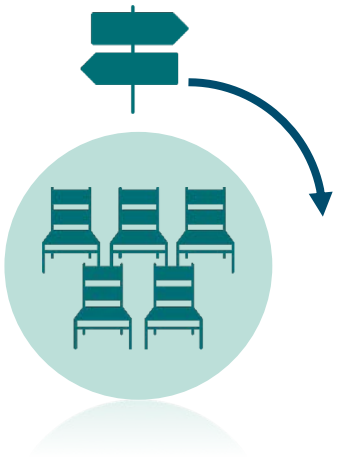
What happens if a patient misses a scheduled appointment?

- The patients record will be filed back in the main filing area after **five working days**
- Should the patient arrive after five working days, the patient will need to follow the **normal process** of retrieving their files, wait for the vital signs and be consulted in the acute stream. Patient will then be sent to book appointment for next visit
- Should a patient come within **five working days after his/her scheduled date**, the patient will be consulted after all the patients allocated to that time slot have been consulted even if they arrive first.

Re-organising patient flow

- Designated waiting areas
- Designated vital sign stations
- Triage of patients
- Designated consultation rooms

Designated waiting area for service areas

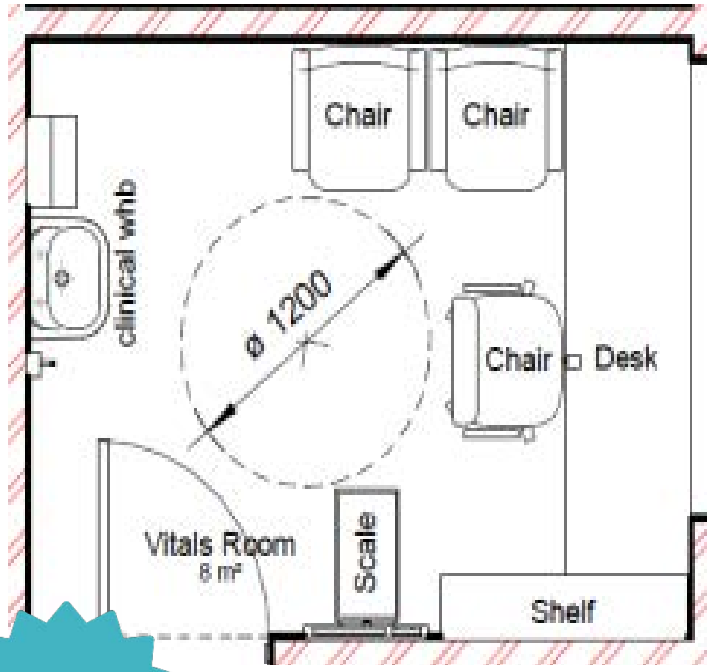


- A clearly marked and **designated waiting area** should be arranged for the different service areas
- This area will **vary between facilities** dependant on the design of the facility and availability of space
- Ideally if a separate entrance and exit is available, each area should have its **own exit and entrance**
- A single row or multiple rows clearly marked or with **different colour chairs** should be placed in such a manner that will facilitate easy patient flow to consultation rooms

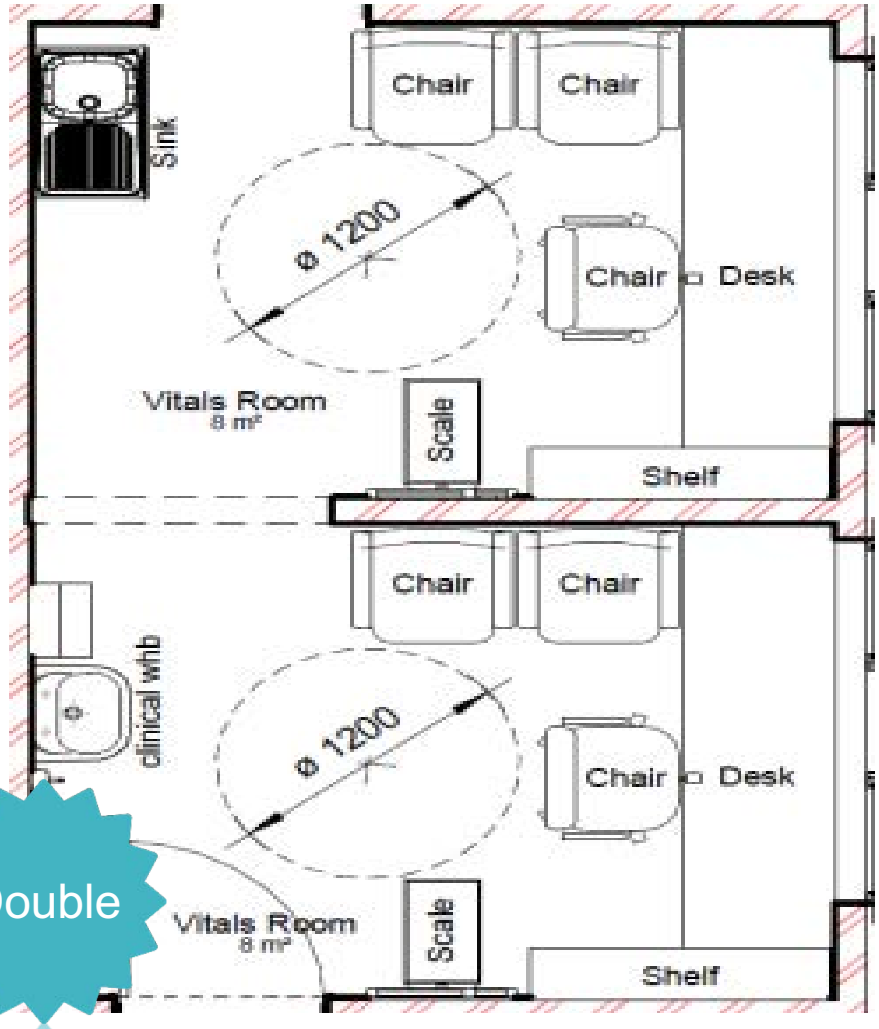
Additional vital signs station

- **Three vital signs monitoring stations** should be established for different streams of care
- This vital sign station should be **conveniently located** between the patient waiting area and consulting room
  - At facilities where less than 30 patients are booked, and there is sufficient equipment available, the blood pressure and blood glucose could be monitored in the consulting room

Single vital sign station versus double vital sign station



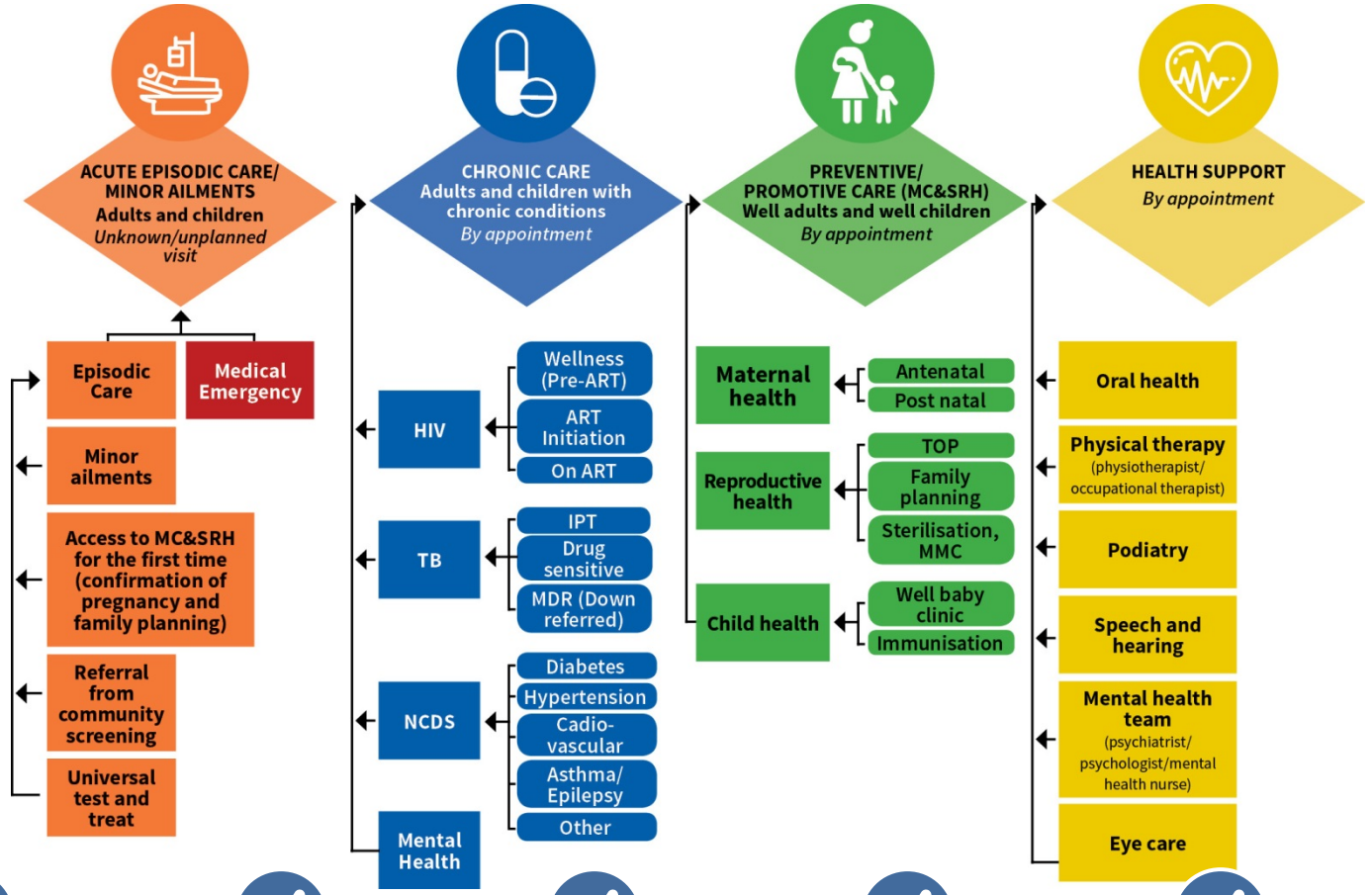
Single



Double

Triaging of patients

The patients should be further **triaged** after completing the vital signs into and directed appropriately



Follow-up patient - New and/or returning

Repeat medication with **normal** vital signs

Repeat medication with **abnormal** vital signs

6 month full examination

Doctor **referral**

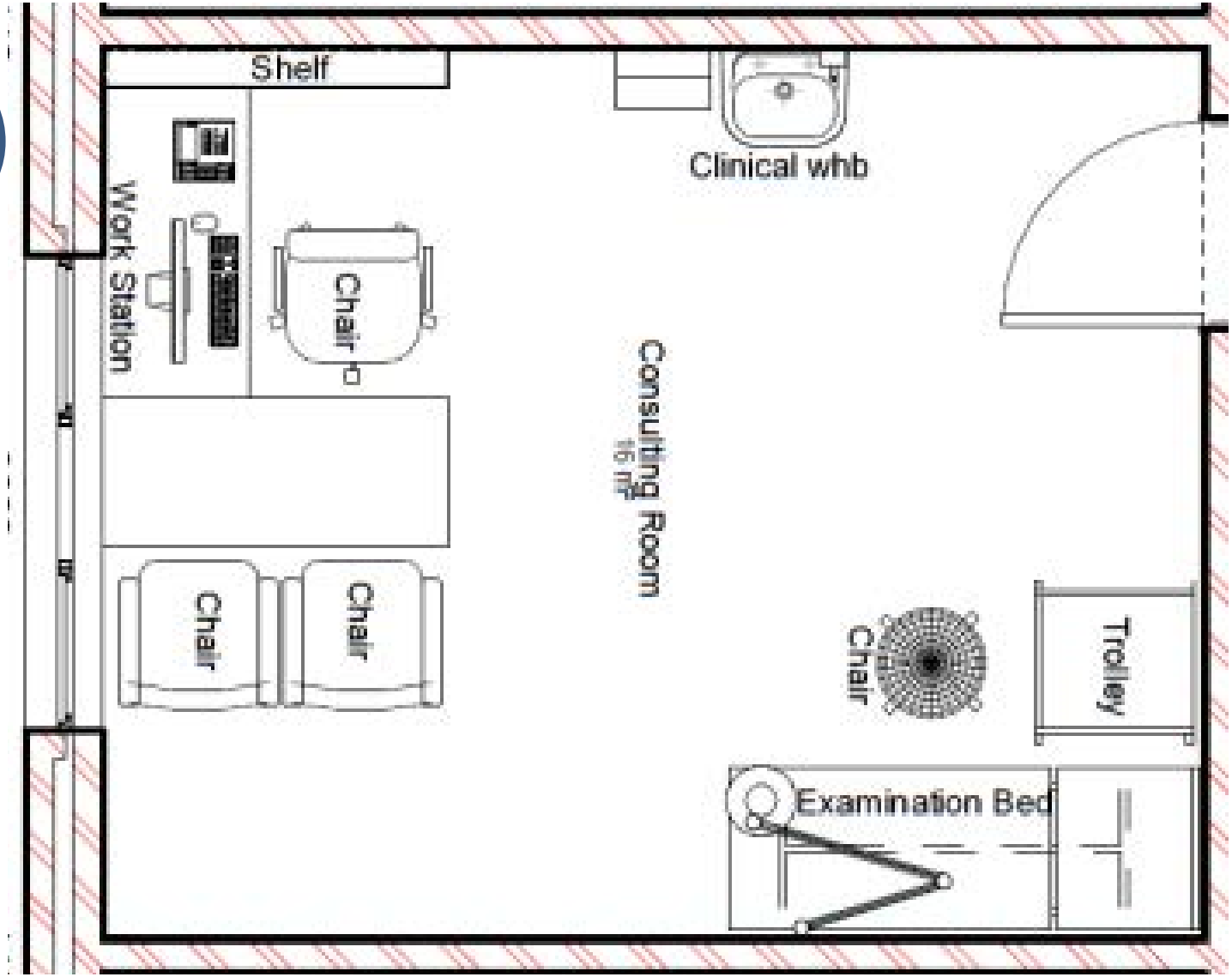
CCMDD medication collection

Designation of consulting rooms

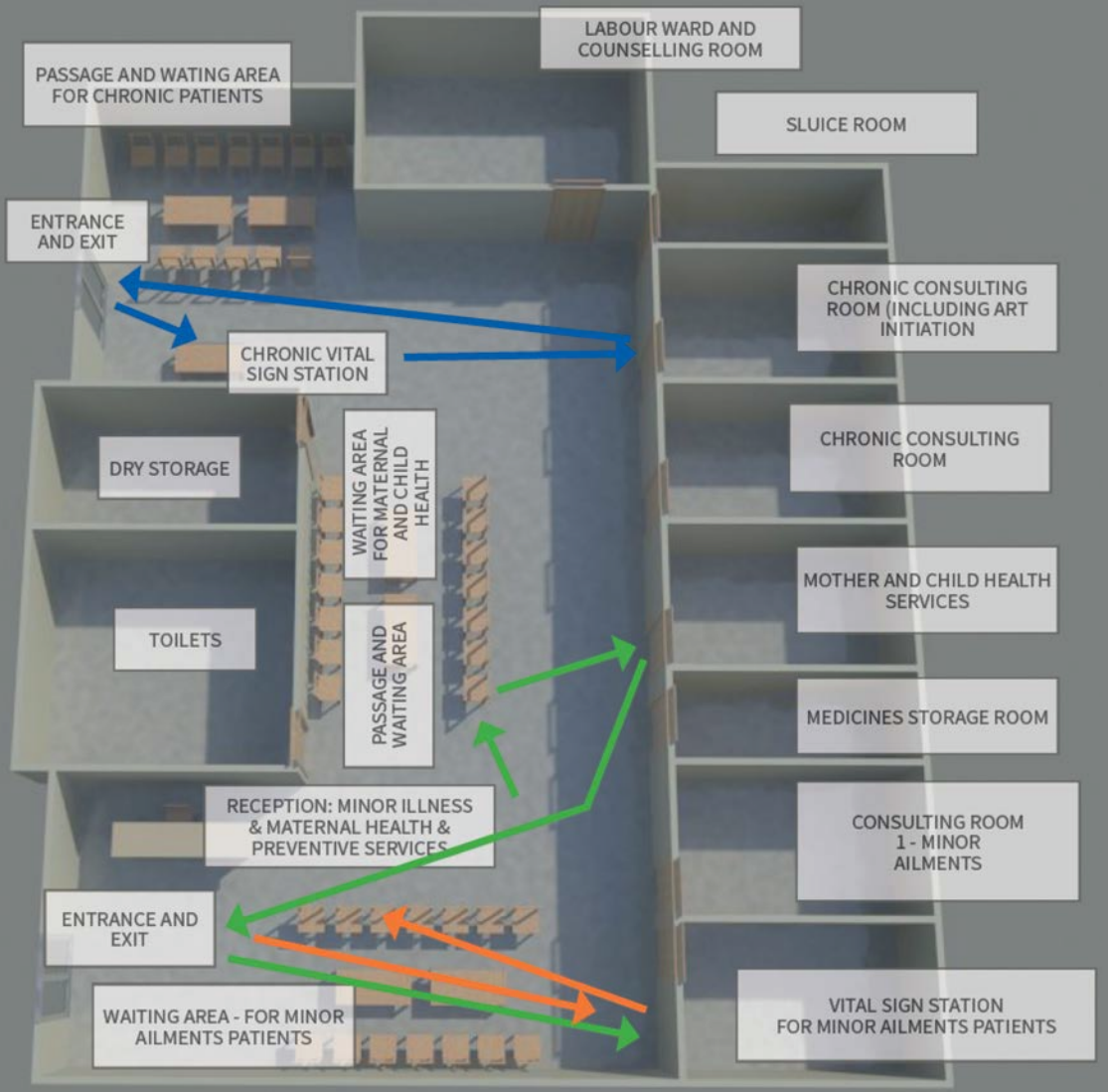
- Consultation rooms will be designated based on **workload**
- Ease of **access**
- No **contra-flows**

Number of patients scheduled/day	Number of consulting rooms to be used	Number of nurses to consult the patients
35	1	1
36-70	2	2
71-105	3	3
106-140	4	4

Consulting room



Re-organised patient flow



Re-stocking of medication: Consultation room

- Orders from consultation rooms should be done **regularly** depending on facility needs.
- **Daily orders** can be submitted for facilities with insufficient cupboard space.
- Facilities rendering a 24-hour service can consider ordering **twice daily**
- One consultation room order form should be used for each individual consultation room.
- **Professional nurse to check for stock on hand for each item** in the consultation room medicine cupboard and calculate the quantity to order by subtracting the on hand quantity from the maximum level.
- **Repeat** for each item to order from the medicine room.

Re-stocking of medication: Consultation room

- Submit order form to the **person responsible** for the medicine room according to the schedule.
- Stock to be issued from the medicine room and **stock card** in medicine room to be completed
- Enter **quantity issued** from medicine storeroom on the consultation room order form.
- Stock should be **collected** from the medicine room.
- Order form to be **signed** as proof of receipt of stock for consultation room.
- **File** the signed order form according to consultation room for record purposes.

Storage of medication in cupboard

*Professional Nurse to pack received stock into the consultation room cupboard **immediately**, according to first-in first-out (FIFO) / first-expiry first-out (FEFO) principles*

CATEGORY	COLOUR	COLOUR INDICATION
Antibiotics	Orange	Orange
Acute Ailments	Neon Yellow	Neon Yellow
Antenatal	Neon Pink	Neon Pink
Asthma	Blue	Blue
Diabetes	Light Blue	Light Blue
Epilepsy	Light Purple	Light Purple
Family Planning	Light Pink	Light Pink
Heart & Hypertension	Red	Red
Hiv	Green	Green
Tb	Yellow	Yellow
Pain	Pink	Pink

Pre-dispensing of medication

- **Two days prior to the patient's appointment**, the patients 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 medication** according to the prescription
- The medication should be **pre-packed in a brown bag** or **clear opaque plastic bag** where available.
- A **sticker** with the patient's name and file number should be placed on the external part of the bag

Pre-dispensing of medication

- The bag **should not be closed** as to validate the medication on dispensing to the patient.
- Once the medication has been pre-dispensed, depending on the allocation of the patient, the medication should then be **placed in the medication cupboard according to alphabetical order** in the **respective consultation rooms** or kept in the pharmacy if it will be dispensed by **pharmacist assistant**

CCMDD facility pick-up

NOTES/SAFETY WARNINGS

a. In the case where the PDoH health facility acts as a PuP, the health facility will have the responsibility for all PuP prodedures/functions. In this instance, medicine parcels must be issued to the patient (or nominated person) by a personnel member of the health PDoH facility.

b. Patients should not pick up facility files.

c. Patients should not go for observation or go to clinician unless indicated.

d. Patients are requested to pick up the medicine parcels in the allocated area for internal CCMDD PuP.

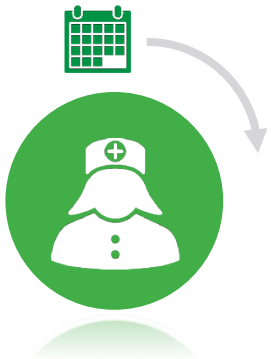
e. Patients should be well informed about the process of the internal PuP by the health facility.

f. Patients without a valid ID or passport number (or any other unique identifier as may be approved by the PDoH) may not be registered with the CCMDD programme and may not register to collect their medicine at an alternate PuP.

SOP for issuing CCMDD medication

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

Scheduling of professional nurses



- The professional nurses allocated to consulting chronic patients should be preferably **APC/PC101-trained or primary care-trained**
- In the interim period whilst all the professional nurses are being trained on APC/PC101, nurses with additional primary healthcare and/or **PALSA Plus** or **NIMART** training should be scheduled to consult chronic patients
- The roster system should be designed for a monthly, **two monthly** or **quarterly rotations** dependent on the number of trained professional nurses available and the number of chronic consultation rooms required

Scheduling of professional nurses

Name of professional nurse	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6

Practical tips

Discard conventional fixed ideas

Think of how to do it, not why it cannot be done

- The pessimist will create all kinds of reasons that something can't be done. The optimistic, forward thinker, on the other hand, knows that **'if the *why* is strong enough, the *how* will come'**
- Focus on the outcome. Then, come up with all the ways that the outcome could possibly be accomplished

Do not make excuses

- Start by questioning current practices. Making excuses for not doing something is easy. Again, focus on the outcome. action. There is no excuse for not trying something

Practical Tips

Do not seek perfection

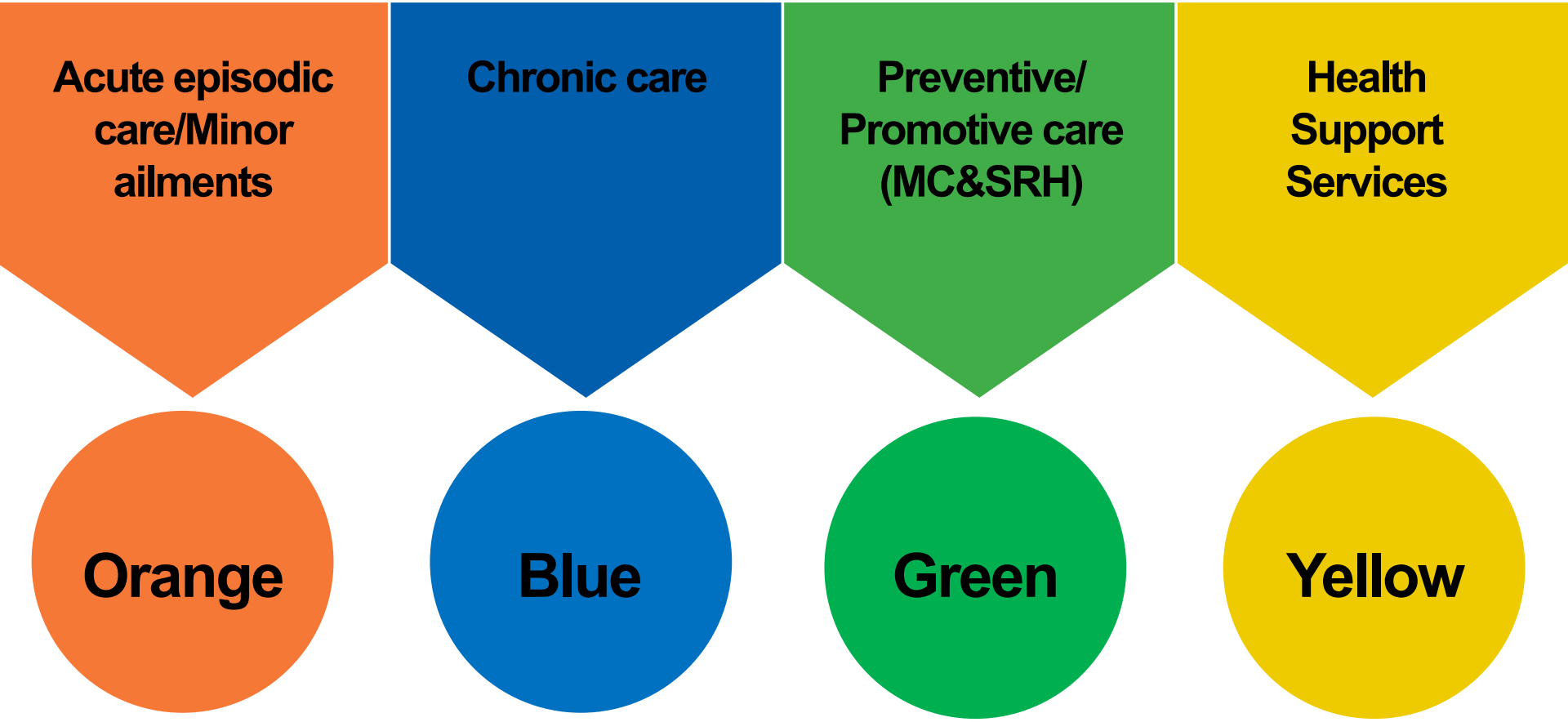
Do it right away even if for only 50% of the target. Once you get to a certain point (whether it's 50% or 80%, or another number that makes sense), then run with it. In other words, *take action*. Then, adjust as you go along

Correct it right away if you make a mistake

Seek the wisdom of ten people rather than the knowledge of one

Service Re-organisation

From ICDM to ICSM: Integrated Clinical Services Management



Organising the facility into streams

The patient process flow at the facility should be organised into **3 clearly designated areas plus one for Health Support Services if offered** that make it easy for patients to access and exit without any cross over.

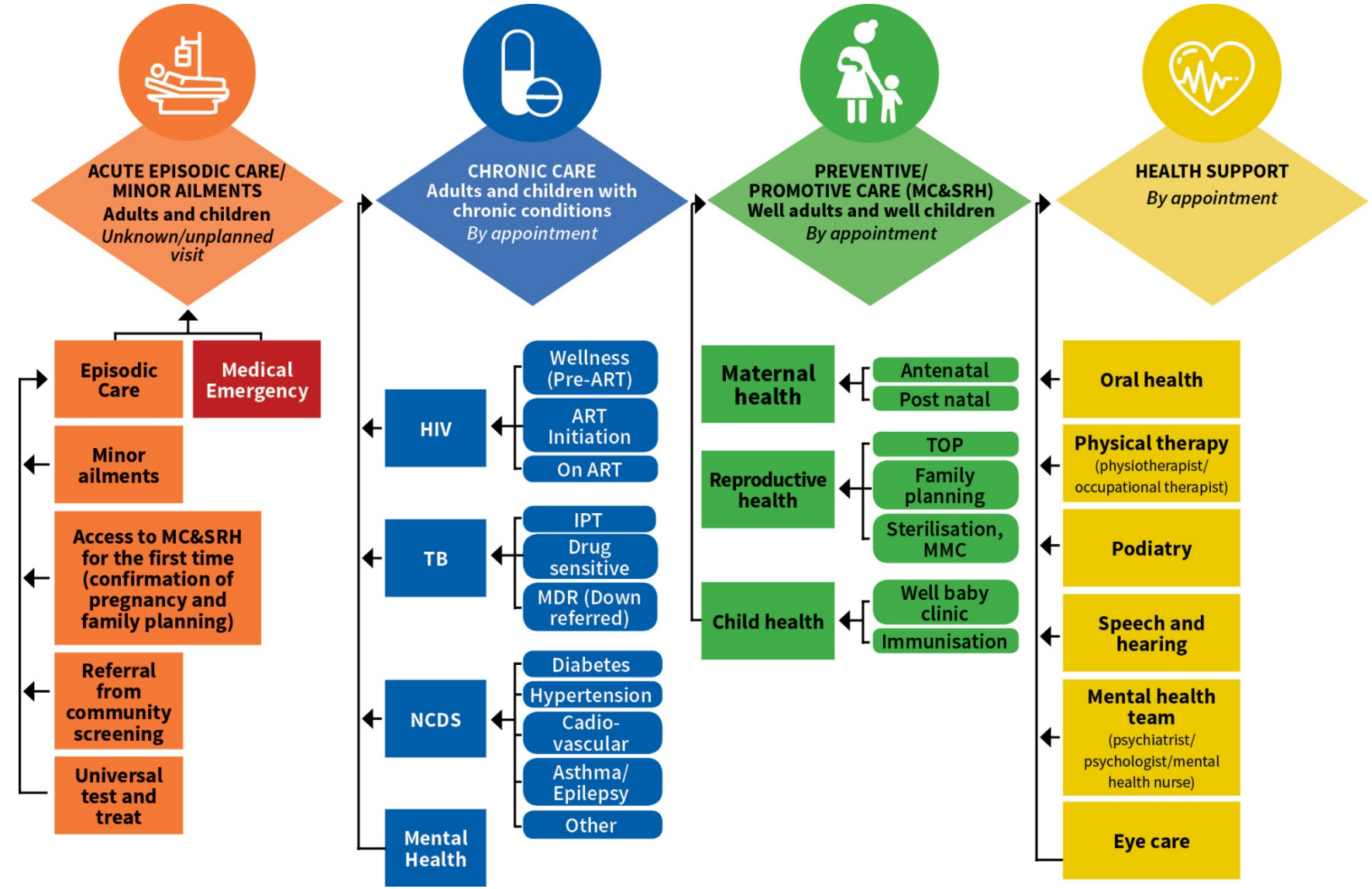
Acute episodic care/Minor ailments should be marked as ***orange***.

Chronic care patients on the ICDM should be marked as ***blue***.

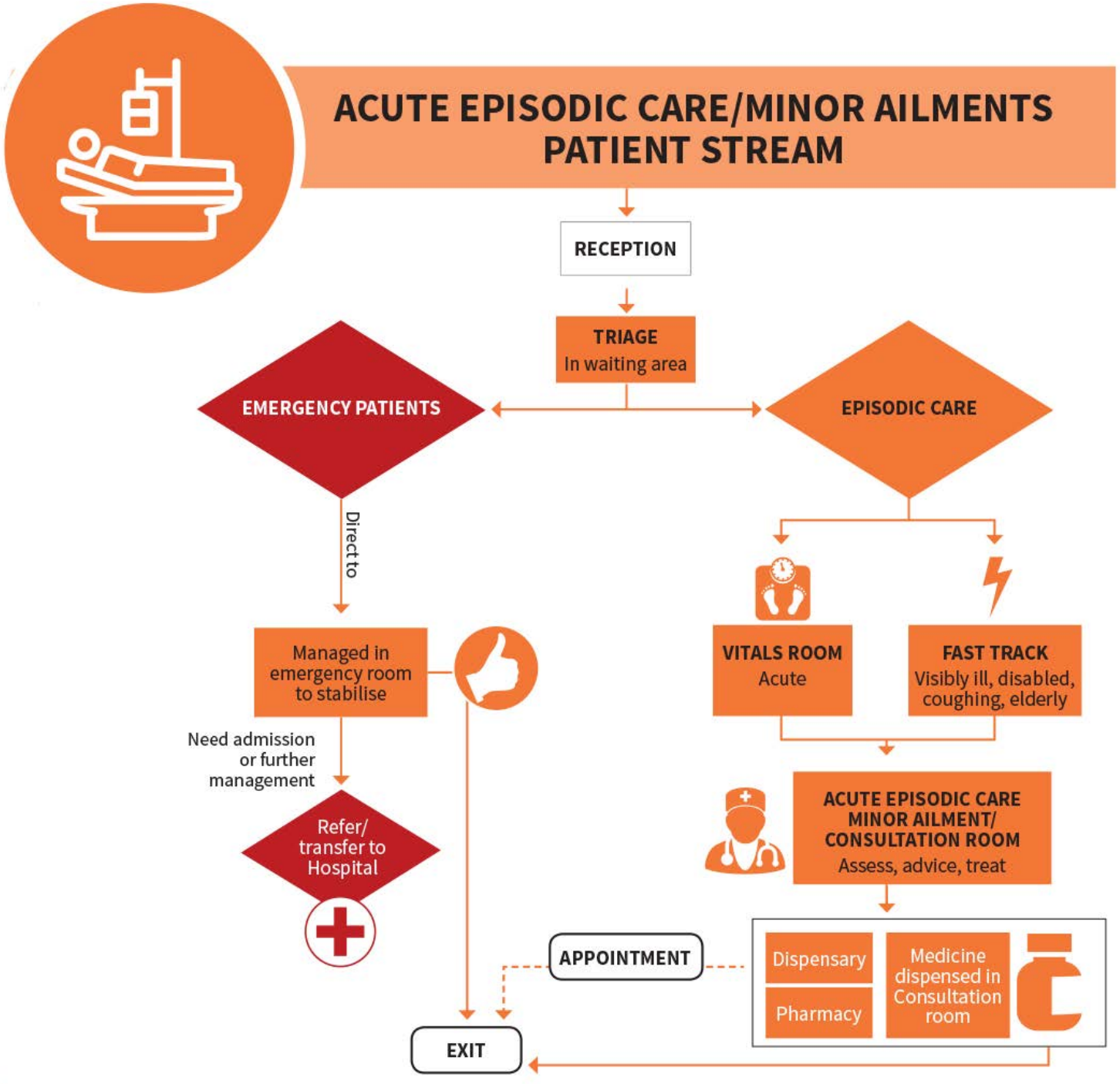
Preventive/ Promotive Care (MC&SRH) should be marked as ***green***

Health Support Services should be marked as ***yellow*** (if offered)

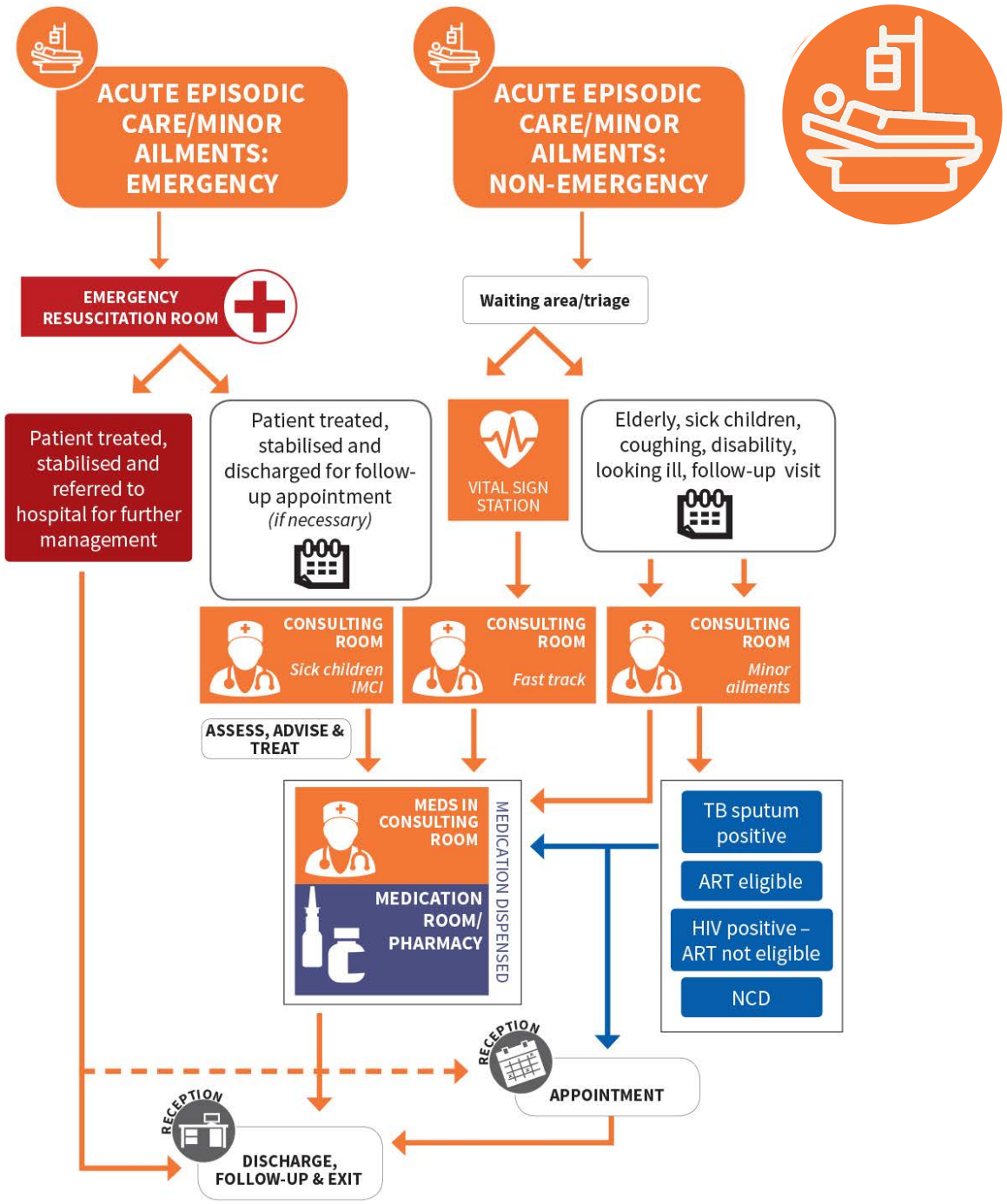
Primary health care service streams



Acute episodic care/Minor ailments patient stream



Acute episodic care/Minor ailments patient stream



Acute episodic care/Minor ailments patient stream

Usually unplanned but maybe planned for patients that have follow-up or review visits for non-recurring illnesses:

- Emergencies
- Non-emergency conditions
- Potentially infectious
- Non-infectious

Urgent action

Any patient that requires **urgent action** should be directed immediately to the Emergency Room.

This patient will not queue for the retrieval of clinical records or vital signs but should be provided immediate attention

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

Adults

Acute episodic care/Minor ailments (first time-unplanned)	Acute episodic care/Minor ailments (potentially infectious)
• Patients will enter the facility and proceed to the **reception** to open a clinical record or retrieve the patient's clinical record • After completing the **registration** process the patient will then be directed to the **triage** or **vital sign station** for acute patients (follow the red/orange footsteps) • Patient will then be directed to the **waiting area** for acute services • From the waiting area patients will follow the queue to be consulted in the relevant **acute** consultation room for treatment, diagnosis and follow-up	Patients presenting to the facility and having any of the following symptoms: • Cough (productive or persistent) • Fever and/or rigors • Diarrhoea • Vomiting • Generalized skin rash Should be fast tracked and consulted as **priority** or in the designated fast tack consultation room in order to avoid the spread of any potential infections

Follow-up

- Patients that have been treated for acute episodic illnesses and have been advised to return for a review or follow-up visit between five and seven days should receive **an appointment**
- Patients should collect file from **reception** and proceed directly to the **designated waiting area** and **consulting room**
- The patient's **vital signs** or other **non-invasive laboratory investigations** should be conducted in the consulting room
- Patients **laboratory** or **other investigation results** should be reviewed in consulting room
- Patient will be treated and discharged. If the patient requires a repeat or follow-up visit again, then the patient will be booked for review

IMCI (0-5 years)

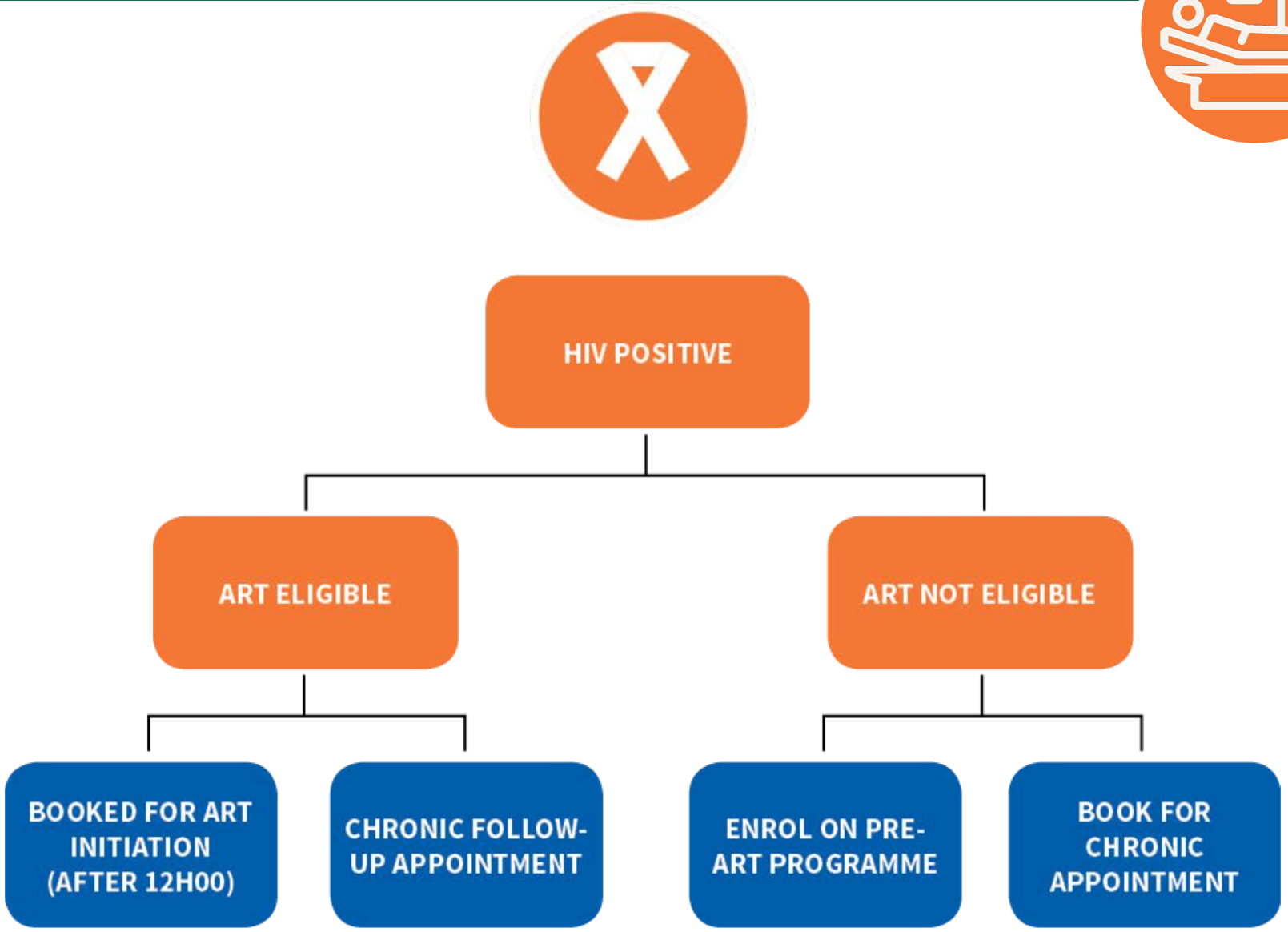
Sick children:
diarrhoea,
cough, rash

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

IMCI (0-5 years)

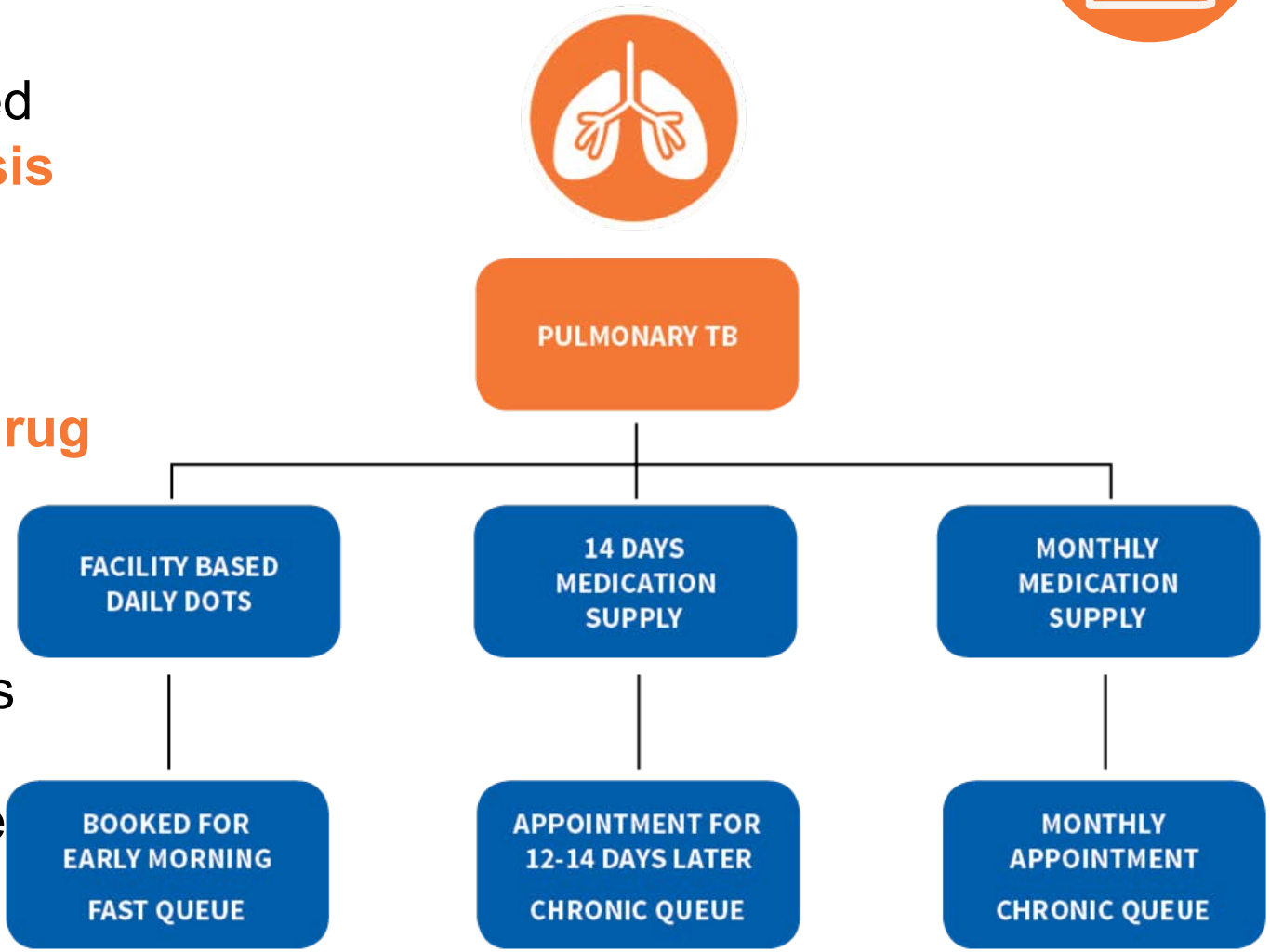
- Sick children presenting for treatment for Acute Episodic Illnesses will generally be unplanned and are recognized as **non-emergency acute patients**.
- Patients will enter the facility and proceed to the **reception** to open a clinical record or retrieve the patient's clinical record
- After completing the **registration** process the patient will then be directed to the **triage** or **vital sign station** for acute patients (follow the red/orange footsteps)
- Patient will then be directed to the **waiting area** for acute services
- From the waiting area patients will follow the queue to be consulted in the relevant **acute IMCI** consultation room
- If the child is potentially infectious then the same process as for adults will be followed
- If the child has a follow-up appointment the process will be similar to that of adults

ART initiation



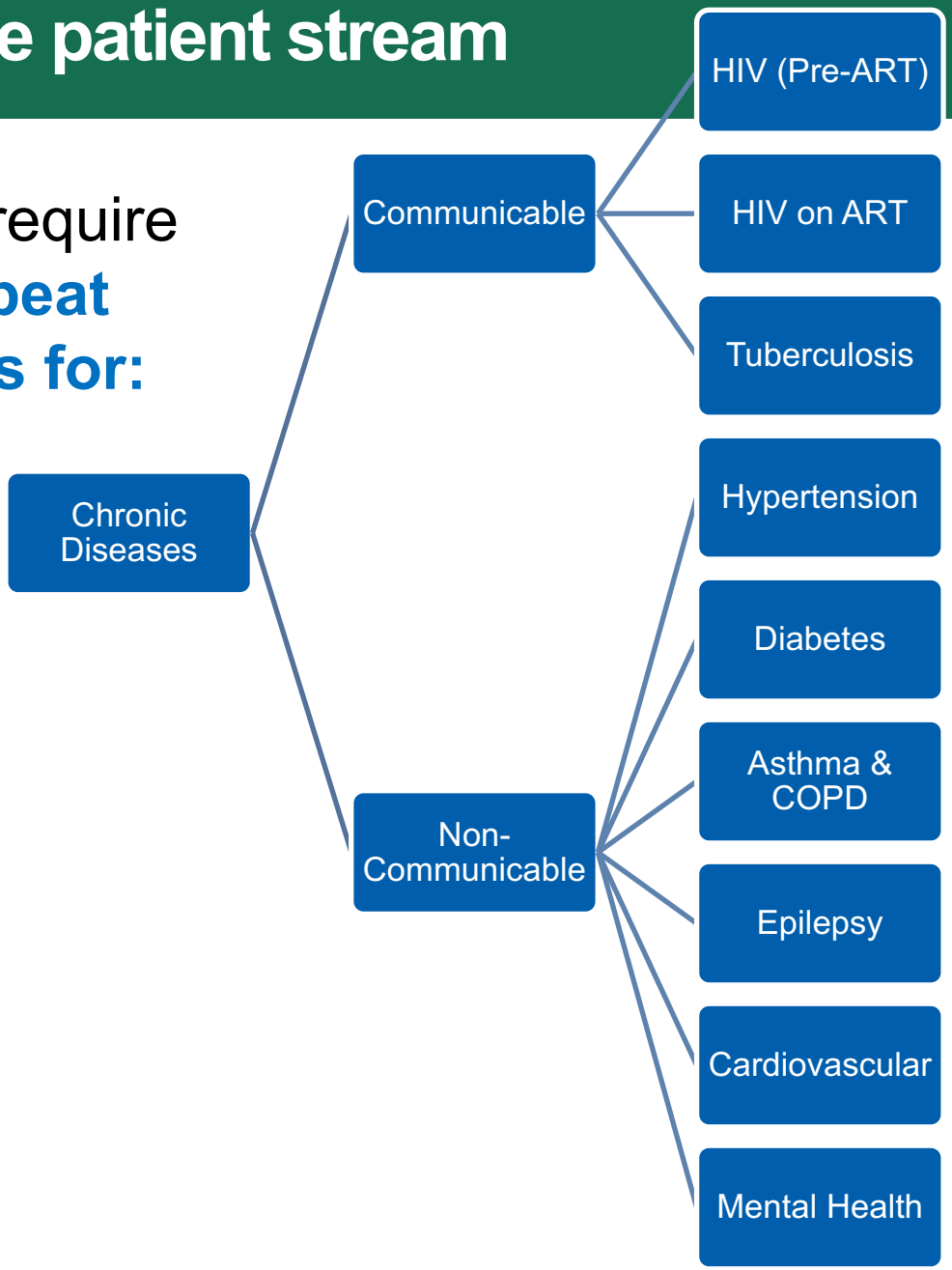
Initiation of tuberculosis medication

- Newly diagnosed with **tuberculosis** will have a Gene-expert conducted to exclude **multi-drug resistant TB**
- Will then be prescribed anti-tuberculosis medication according to the regimen.

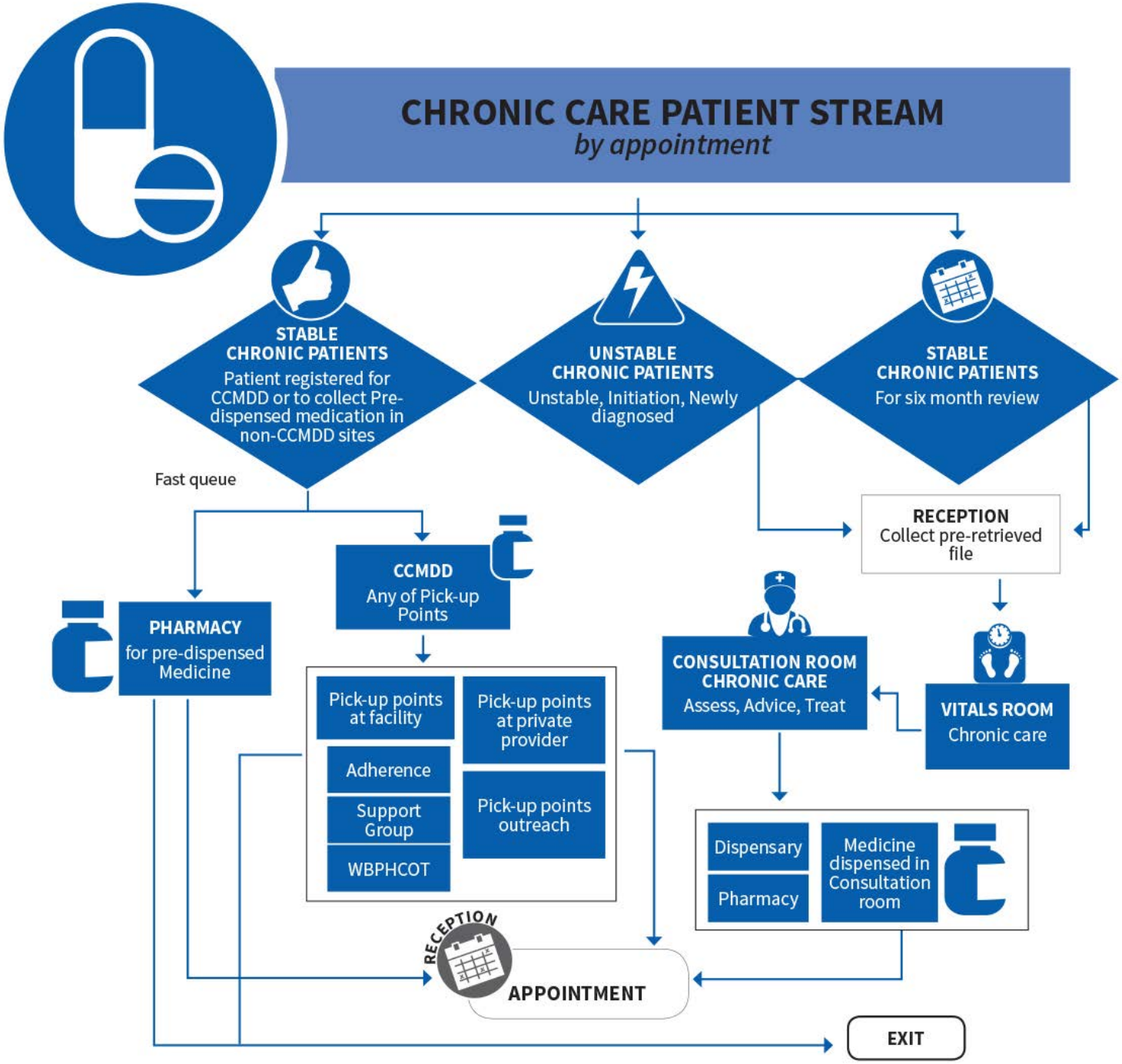


Chronic care patient stream

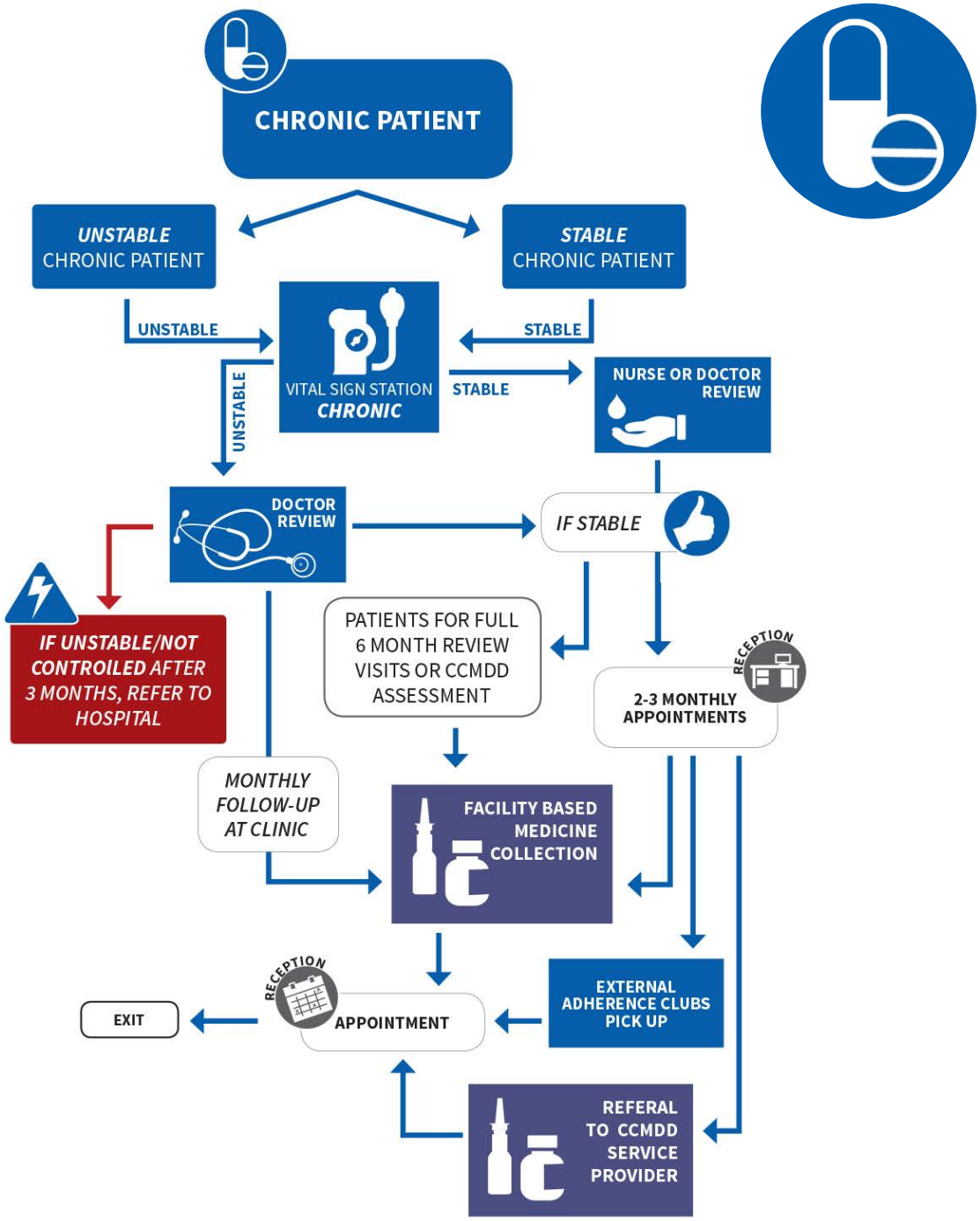
Patients that require **long term repeat consultations for:**



Chronic care patient stream



Chronic care patient stream



Unstable chronic patient

- Patient whose vital signs parameters are above the normal as per APC/PC101 or the patient is displaying signs of end organ damage due to the chronic conditions.
- These patients are **high-risk** patients and require **pro-active management**.
- Ideally these patients should be referred to the doctor for consultation and should be consulted on a monthly basis.
- These patients should be provided with a scheduled appointment (refer to appointment booking)
- The comments section in the appointment scheduling should reflect **'Dr. Appointment'**
- The patients clinical records should be retrieved 48-72 hours prior to the scheduled appointment
- All the necessary laboratory investigation results should be updated in patients file

Unstable chronic patient

- When the patient arrives, the patient will go directly to the **chronic reception cubicle** or chronic vital station (pre-retrieved files should be here with list)
- After completing the vital signs patient should then sit in the queue to see the **healthcare professional (HCP)**.
- After the HCP consults the patient :
  - If the patient parameters are normal and the patient's risk status has declined, the patient can then be categorized as a **stable** chronic patient and then referred to the reception to make an appointment or be screened for eligibility for **enrolment on the CCMDD programme**

Stable chronic patient

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

- Patients for full **six-month review** visits or CCMDD assessment
- **Facility based** medicine collection (direct) or **adherence clubs**
- Central Chronic Medicine Dispensing and Distribution (CCMDD)

Stable chronic patient

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

Facility based medicine collection (non-CCMDD)

- The patient should receive an appointment for **two months** depending on medication supply
- When the patient attends for medication collection, the patients clinical record should have been **pre-retrieved** with the prescription updated
- Patient medication should be **pre-dispensed**
- Patient should enter the facility and go directly to chronic stream for **vital signs observation**
- If all parameters are **normal patients should collect medication and receive an appointment** for next visit
- At **month five** patient should be provided for an appointment for review at **month six**

CCMDD eligible (external provider)

- Currently, if the patient is on ART and has an additional chronic condition, the patient is **eligible for the CCMDD** programme
- The patient should be **assessed for the CCMDD** programme and if the patient fulfils criteria, the prescription should be forwarded to the CCMDD service provider
- The patient should then be provided a **six-month appointment for review** (clinical examination and laboratory investigations if applicable)

CCMDD eligible (facility collection point)

If medication is pre-dispensed and delivered to facility as patient pick-up point

- Patient does not need to **retrieve the clinical record**
- Patient does not need **vital signs monitoring**
- Patient should be directed to **CCMDD point** and provided with medication
- **CCMDD documentation** needs to be completed
- Patient should receive **six month appointment** to attend facility

Down referral to WBPHT

- **A patient is classified as stable if:**
  - Patient has been adherent to appointment schedules for at least three months
  - All vital signs over the three months have been normal
  - No evidence of deterioration in condition or complications
- **Where there is no CCMDD** attached to the facility, A patient who is **stable** should be down referred to the community healthcare worker (CHW) for management and should be given an appointment for review in six months
- A patient who defaults his/her appointment and needs to be **traced**

Steps to be followed in down referral

- Once the patient is classified as stable, the patient's name should be entered into the down **referral dairy**
- The patient should be mapped with a **Ward Based Primary Health Care Outreach Team (WBPHCOT)** and specifically a **CHW**
- Ideally, the patient should be introduced to **the CHW at the facility**, so that a communication channel can be open
- However, if this is not possible, then the patient should be provided with the CHW name and contact details
- The patient should be asked when is the **most convenient time and day** for the CHW to visit
- The **date** that the patient should receive the refill of medication should be entered into the dairy
- The patient should be provided with the clinic number and **contact numbers** for any emergencies
- When the patient receives the medication, the patient should complete **acknowledgement of receipt** and the CHW should return this to the facility for storage in patient's records

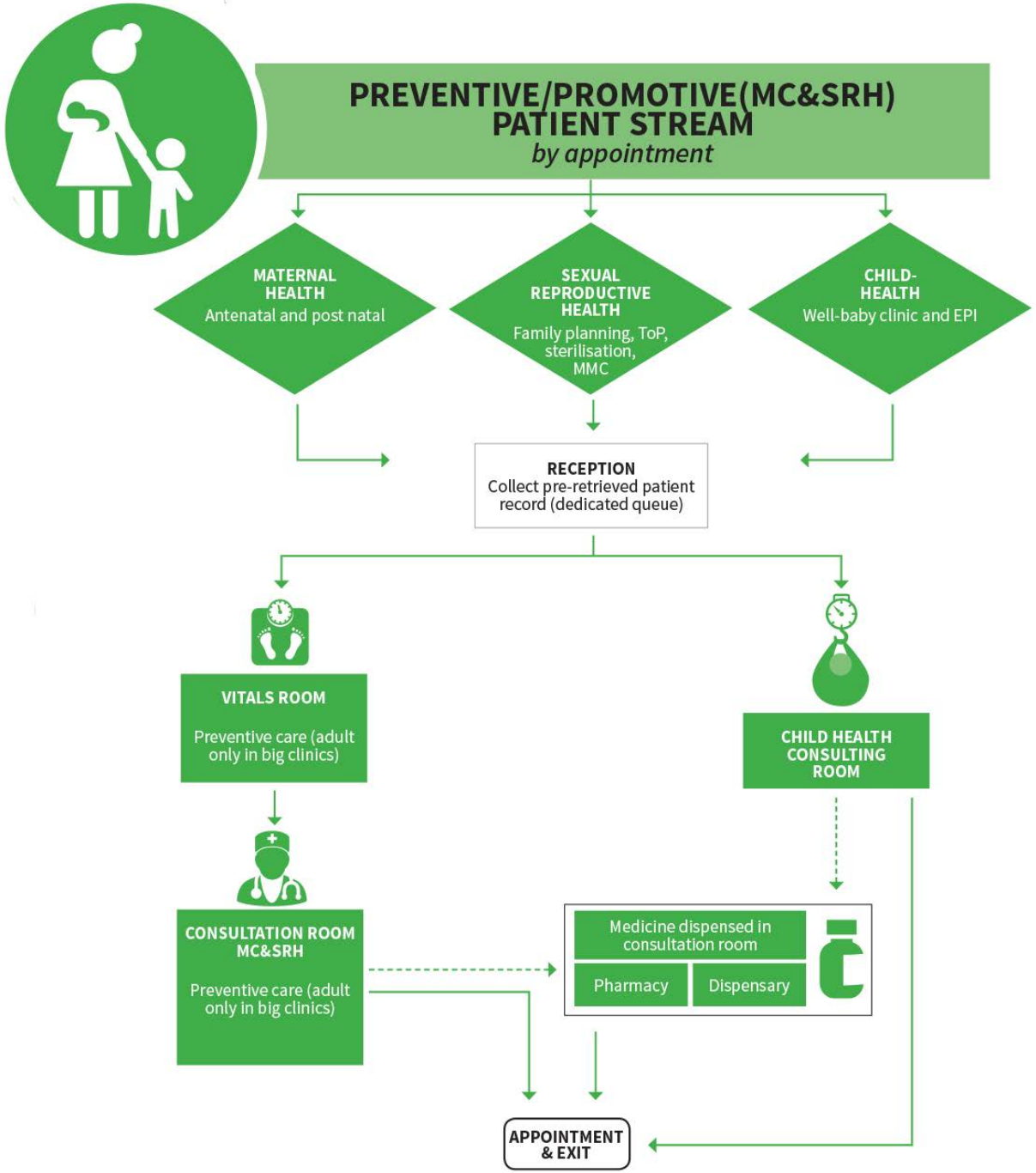
Down referral diary format/patient down referral to CHW

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

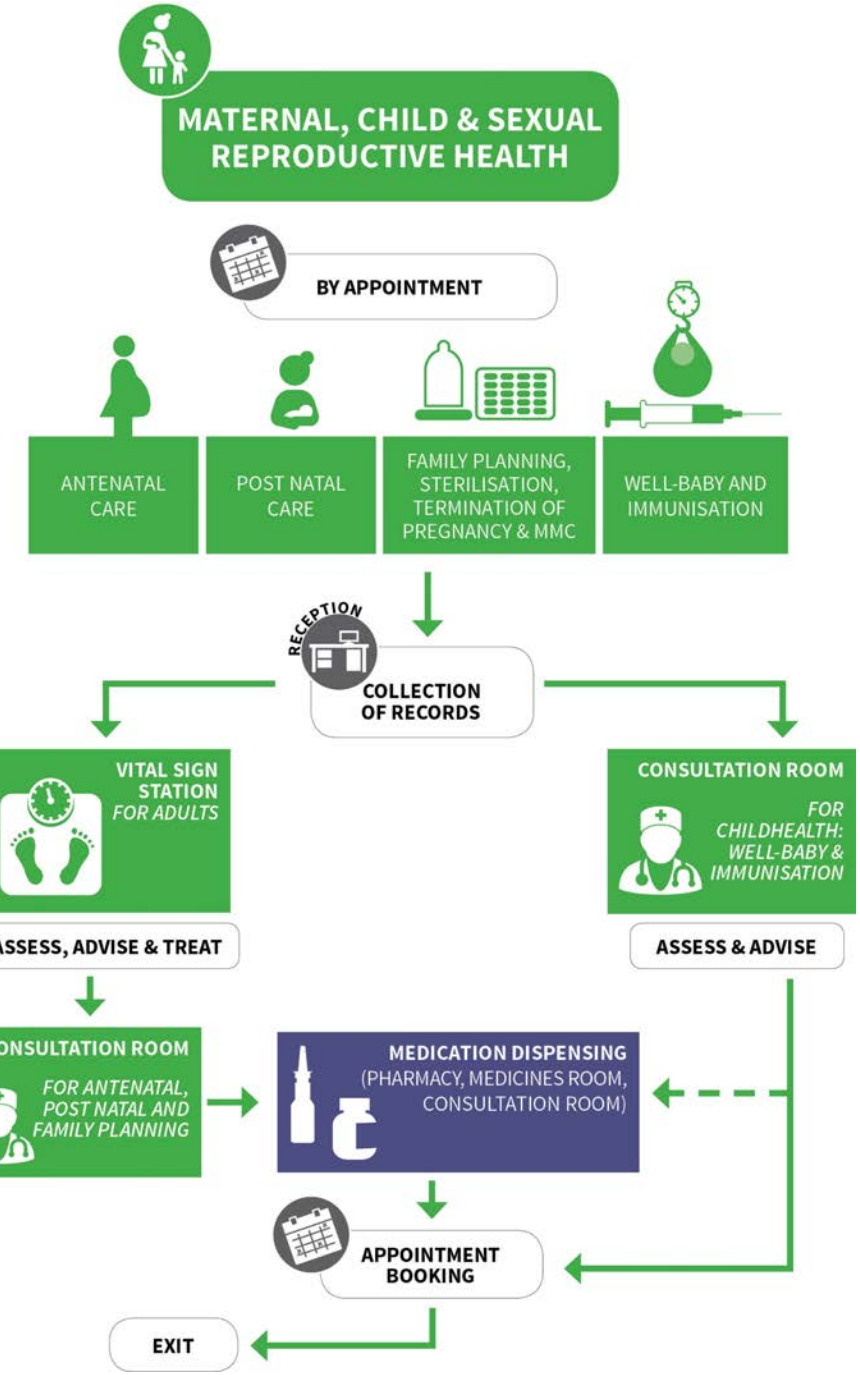
Chronic patient with acute problem

- Should a patient with chronic conditions present with an acute condition **on date of appointment** whether for review or medication collection then patient will be **consulted in chronic room**
- Should a patient present on any other date then the patient will **join the acute queue**

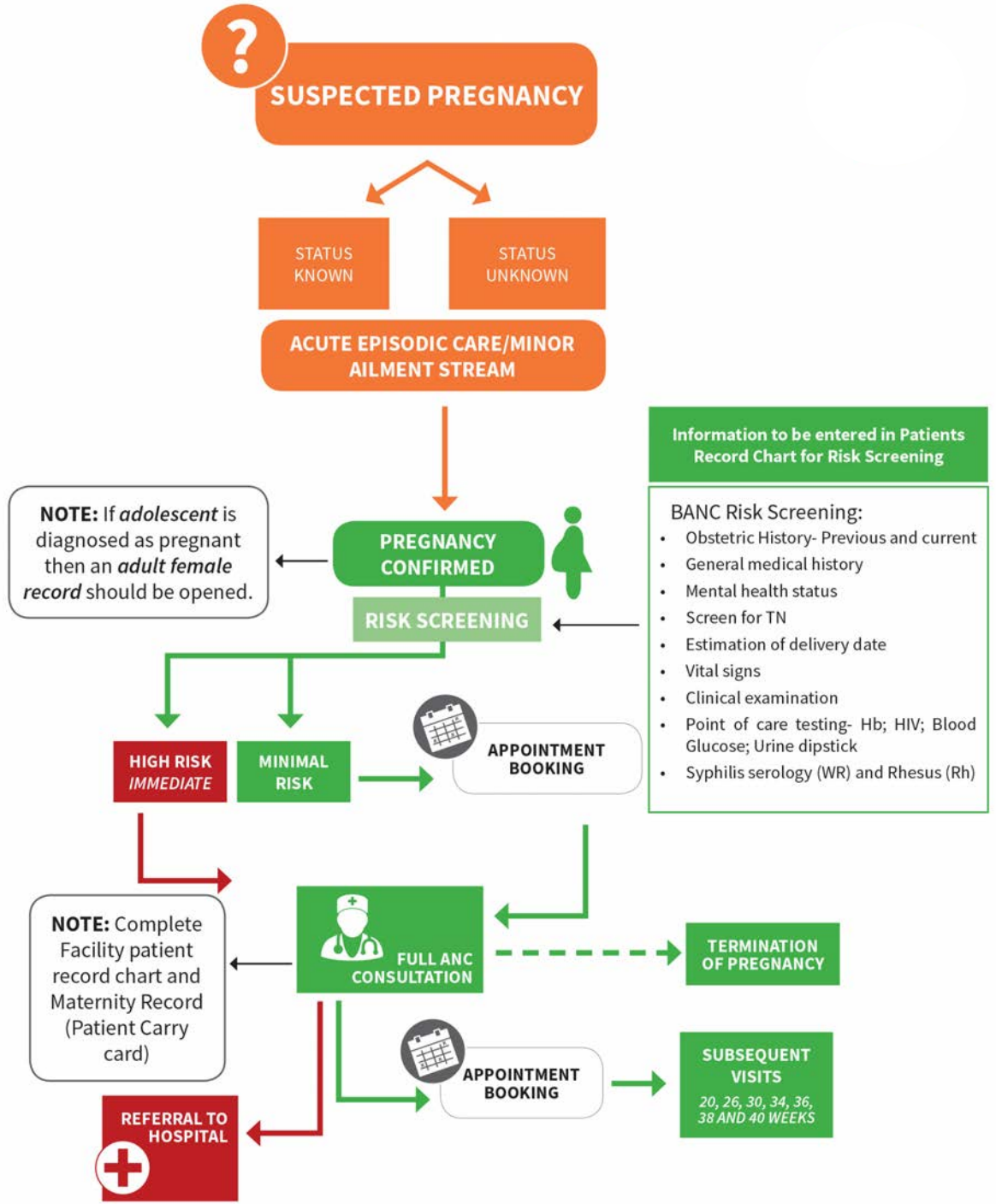
Preventive/promotive (MC&SRH) patient stream



New process flow for MC&SRH



Process flow for antenatal clients



Risk screening after confirmation of pregnancy

Name of patient _____ Clinic record number | | | | | | | |

Address _____ Telephone _____

_____ Cell _____

INSTRUCTIONS: Answer all the following questions by placing a cross mark in the corresponding box

Obstetric History	No	Yes
1. Previous stillbirth or neonatal loss?		
2. History of 3 or more consecutive spontaneous abortions		
3. History of a congenital abnormality in previous pregnancy		
4. Birth weight of last baby < 2500g?		
5. Birth weight of last baby > 4000g?		
6. Last pregnancy: hospital admission for hypertention or pre-eclampsia/eclampsia?		
7. Previous surgery on reproductive tract (Caesarean section, myomectomy, cone biopsy,cervical cerclage)		
Current pregnancy		
7. Diagnosed or suspected mulitple pregnancy		
8. Age < 16 years		
9. Age 37 years or older (at conception)		
10. Isoimmunisation Rh (-) with antibodies in current or previous pregnancy		
11. Vaginal bleeding		
12. Pelvic mass		
13. Diastolic blood pressure 90mmHg or more at booking		
General medical		
14. Diabetes mellitus on insulin or oral hypoglycaemic treatment		
15. Cardiac disease		
16. Renal disease		
17. Epilepsy		
18. Asthmatic on medication		
19. Tuberculosis		
20. Known 'substance' abuse (including heavy alcohol drinking)		
21. Any other severe medical disease or condition		

Please specify _____

A yes to any ONE of the above questions (i.e. ONE shaded box marked with a cross means that the woman is not eligible for the basic component of antenatal care

Is the woman eligible (circle) No Yes

If NO, she is referred to _____

Date _____ Name _____ Signature _____

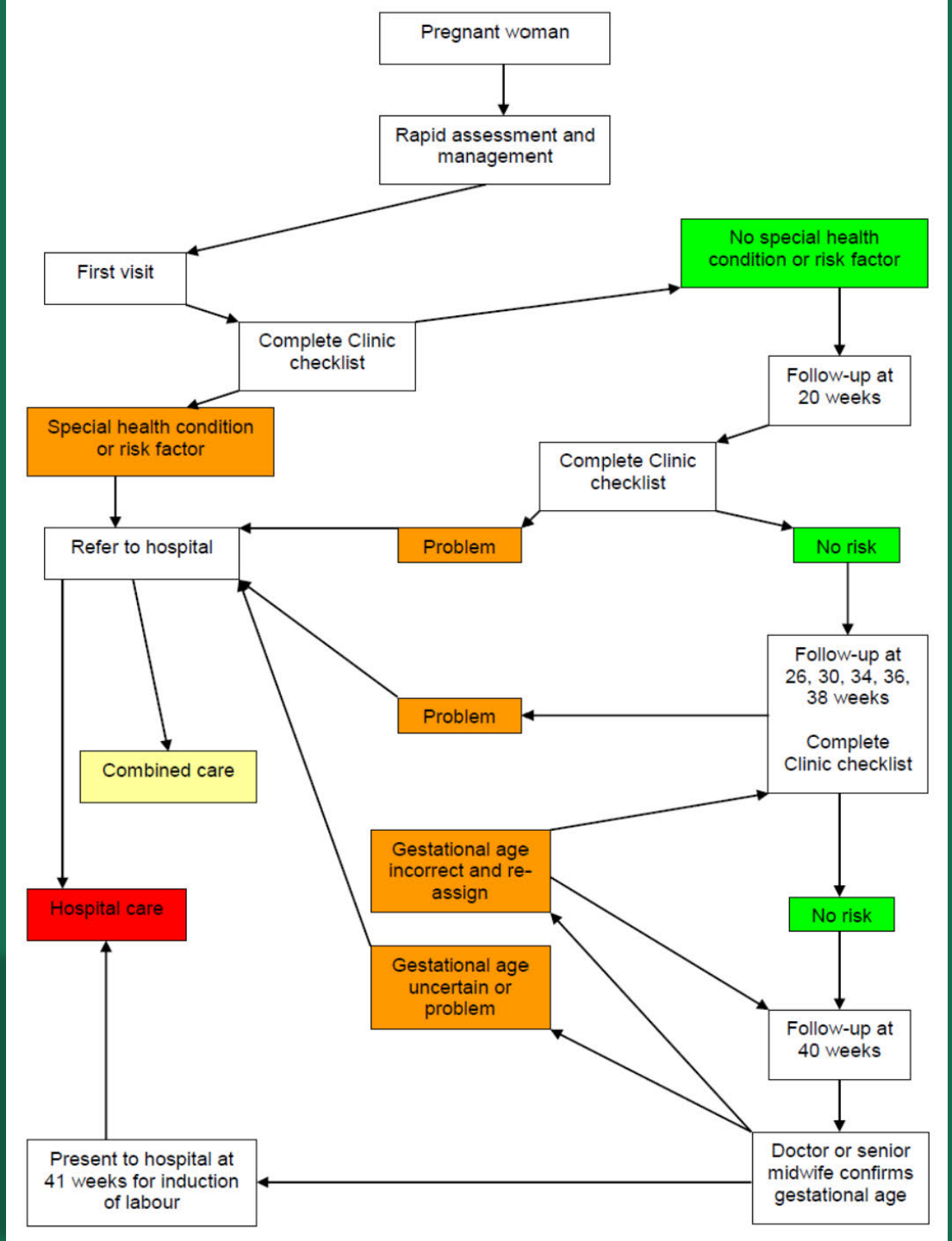
(staff responsible for antenatal care)

Information to be entered in Patients Record Chart for Risk Screening

BANC Risk Screening:

- Obstetric History- Previous and current
- General medical history
- Mental health status
- Screen for TN
- Estimation of delivery date
- Vital signs
- Clinical examination
- Point of care testing- Hb; HIV; Blood Glucose; Urine dipstick
- Syphilis serology (WR) and Rhesus (Rh)

Organisation of antenatal care



High-risk pregnancy

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

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

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

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

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

History taking

Physical Examination

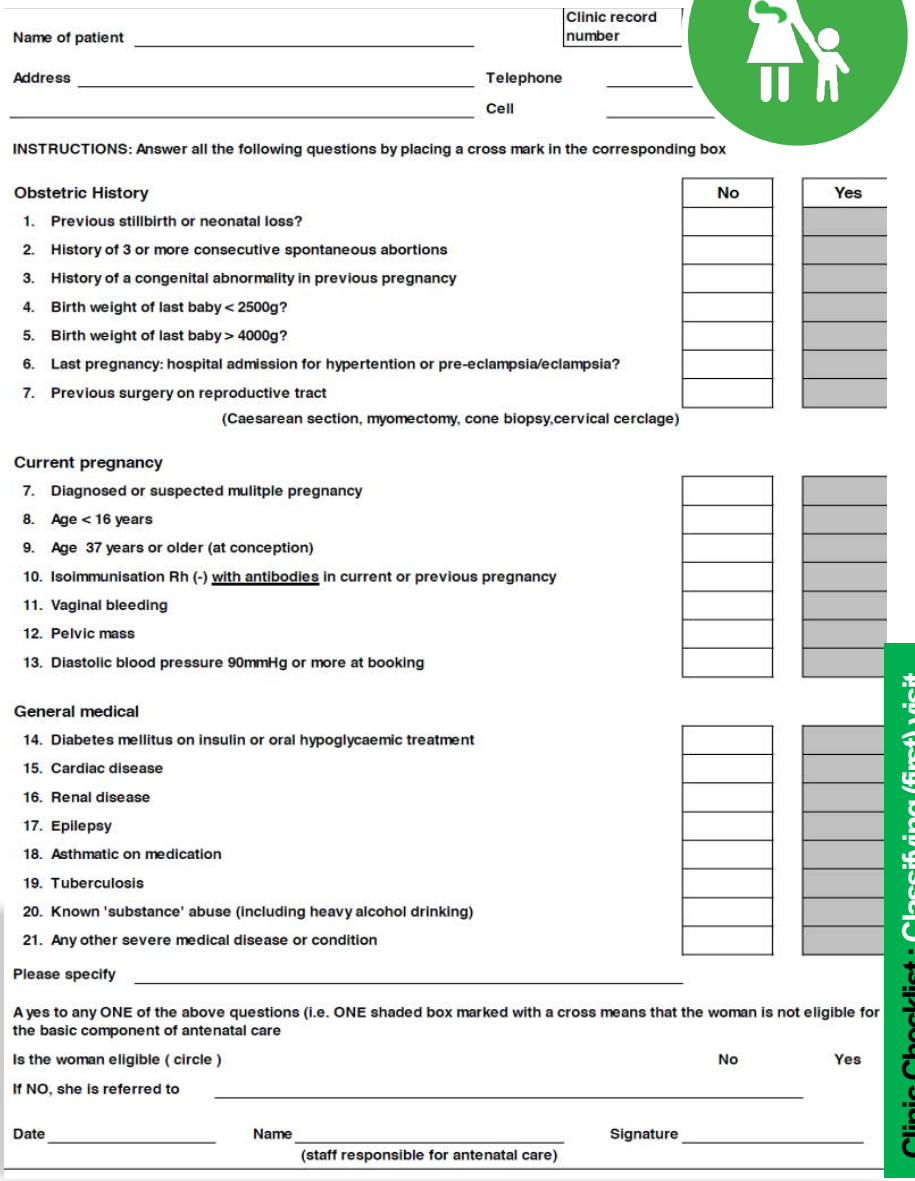
- General examination
- Systematic examination including dental
- Pregnancy specific examination- palpation, symphysis fundal height measurement, mid upper arm circumference

Screening investigations

- Syphilis serology
- Rhesus
- Haemoglobin
- HIV
- Urine dipstick for protein and glucose

Special investigation if mandated

- Blood group
- Blood glucose
- Cervical smear
- Rubella
- Down syndrome screening
- Ultrasound



Name of patient _____ Clinic record number

Address _____ Telephone _____

_____ Cell _____

INSTRUCTIONS: Answer all the following questions by placing a cross mark in the corresponding box

Obstetric History	No	Yes
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7. Previous surgery on reproductive tract (Caesarean section, myomectomy, cone biopsy,cervical cerclage)		
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14. Diabetes mellitus on insulin or oral hypoglycaemic treatment		
15. Cardiac disease		
16. Renal disease		
17. Epilepsy		
18. Asthmatic on medication		
19. Tuberculosis		
20. Known 'substance' abuse (including heavy alcohol drinking)		
21. Any other severe medical disease or condition		

Please specify _____

A yes to any ONE of the above questions (i.e. ONE shaded box marked with a cross means that the woman is not eligible for the basic component of antenatal care

Is the woman eligible (circle) No Yes

If NO, she is referred to _____

Date _____ Name _____ Signature _____

(staff responsible for antenatal care)

Clinic Checklist : Classifying (first) visit

Subsequent antenatal visits

Pregnancy confirmation (usually within the first 14 weeks)

Thereafter **follow-up visits** should be scheduled at 20, 26, 30, 34, 36, 38 and 40 weeks' gestation

Content of subsequent antenatal visits

- **Ask** about general well-being, fetal movements, danger symptoms and any problems
- **Check** the blood pressure, heart rate and colour of the mucous membranes
- **Measure** the symphysis-fundal height (SFH) in cm. Plot the SFH on the graph against the gestational age and compare with the 10th, 50th and 90th centiles for gestational age and with previous measurements
- **Palpate** the presenting part from 34 weeks; palpate carefully for possible breech presentation at 34-36 weeks
- **Test** the urine for protein and glucose at each visit
- **Repeat** syphilis and HIV tests at 32 wees for all women who tested negative at initial testing
- **Repeat** blood tests: Hb at 32 and 38 weeks
- **Repeat** information for danger signs pregnancy, and review delivery and transport plans, as well as feeding and contraception choices
- At 38 weeks, **remind** the woman to bring her MCR with her when she presents to the clinic or hospitals in labour

ANC record to be completed

First visit for all women at first contact with clinics, regardless of gestational age. If first visit later than recommended, carry out activities up to that time

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

Family planning

First visit

- Patient will enter the facility through the **Acute episodic care/Minor ailments stream**, be registered, have vital signs conducted and any medical contra-indications will be excluded.
- The patient will then receive their contraception in the **Acute episodic care/Minor ailments stream** and be transferred to the appointment desk for subsequent visits in the **Preventive/Promotive care (MC&SRH)** stream

Family planning

Subsequent visits

- Patient will receive appointments for **next visits**
- Patient will present direct to **Preventive/Promotive care (MC&SRH)** stream and will be fast tracked to the relevant consultation room as per appointment schedule

Cervical smears

- All eligible women attending the facility irrespective of the stream will receive **cervical smears on the same date of their consultation** if possible
- There will be no appointments and special days for cervical smears only
- **Cervical smear results should be checked regularly** and patients contacted if any abnormalities reported

Well-baby and immunisation

- A designated area for **post natal care, well-baby checks and immunisation** should be available.
- **Routine post natal care and well-baby check up** may not be planned if patients have not delivered at the current facility and therefore **should be anticipated.**
- First immunisation visits may also not be a planned visit. So the facility should **use historical data** to assume the number of patients that will be attending and provide open slots in the appointment schedule

Well-baby and immunisation

Follow-up immunisation and baby checks:

- The **follow-up appointment** and subsequent **immunisations** should be scheduled.
- Mother should receive the appointments that **coincide** with the mothers own respective appointments.

Essential post natal care

Patient Details Discharge (Mother)

Date: _____
Exam by: _____
Delivered at: _____

Mother's Name:

Hosp No

Address:

Tel/cellphone no

Age:	Parity:	Gravidity

ANC complications

Delivery route :	
Birth weight	
Date of delivery	
Gestational age	

Complications in labor:

Postpartum course:

UMAC	Rh	RPR	Hb

Code:		
Vitamin A given	**YES**	**NO**
Iron/folate given	**YES**	**NO**

Type of contraception

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

Examination within 1 week (Mother)

Date: _____
Exam by: _____
Clinic: _____
Clinic No _____

+Ask the mother the following

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

+Examine the following

UMAC:	Temp	Pulse	BP

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

+Test the following

Urine normal	**YES**	**NO**

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

Examination at 6 weeks (Mother)

Date: _____
Exam by: _____
Clinic: _____

+Ask the mother the following

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

+Examine the following

UMAC	Temp	Pulse	BP

If breast feeding, are nipples cracked / breast inflamed	**YES**	**NO**

+Test the following

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

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

CD4 Taken	**YES**	**NO**	**N/A**

Type of contraception

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

Patient Details Discharge (Infant)

Date: _____
Exam by: _____
Delivered at: _____

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

Examination at discharge

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

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

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

Permission for PCR

YES	**NO**	**N/A**

Mother's name

Signature(mother)

Signature(Witness)

Examination within 1 week (Infant)

Date: _____
Exam by: _____
Clinic: _____

Infant's name

+Ask the following

Feeding?	EBF	FF	Mixed

Problems	**YES**	**NO**
Passed urine?	**YES**	**NO**
Passed stool?	**YES**	**NO**

+Examine the following

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

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

Examination at 6 weeks (Infant)

Date: _____
Exam by: _____
Clinic: _____

+Ask the following

Feeding?	EBF	FF	Mixed

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

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

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

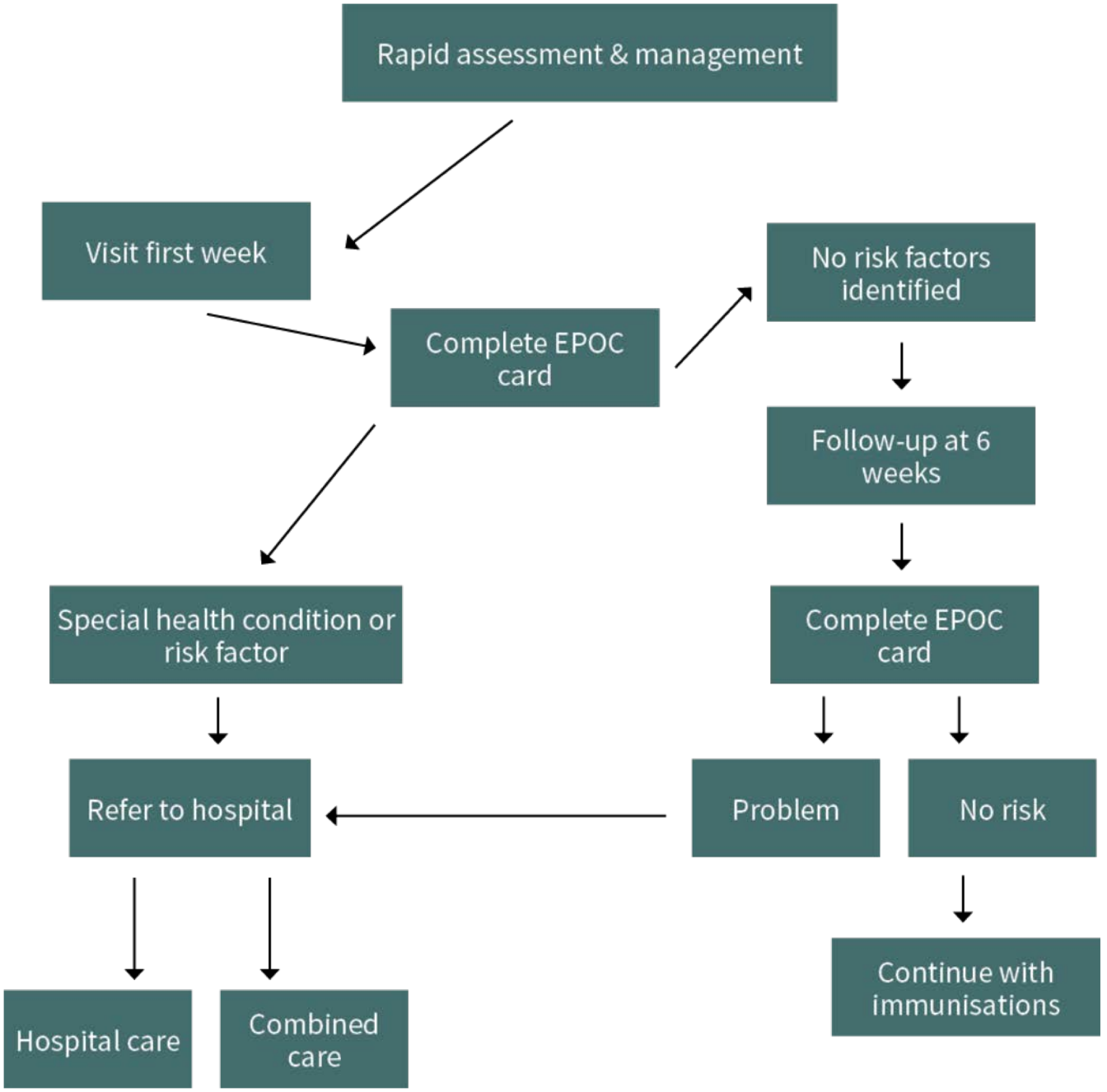
*** If ticks in shaded areas comment on back. Refer, if cannot treat**

- **Vaccinate**

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

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

Essential post natal care



Health Support Services

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

Health Support Services

Internal referral

Patients will already have the facility clinical record and should be directly referred for **assessment as an unplanned visit**

Follow-up patients

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

Health Support Services

Down referrals

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