Integrated Clinical Services Management

ICSM model

Health Service Re-organisation
ICSM implementation

PRE-IMPLEMENTATION
- Briefing of Staff
- Selection of Start Date
- Facility ICSM Team
- Community Awareness

DATA COLLECTION
- Facility Walk Through
- Facility Data Collection
- Waiting Time Survey
- Human Resource Training Audit

DATA ANALYSIS
- Number of Patients to be Booked Daily
- Number of Consultation Rooms per Stream
- Process Flow
- Human Resource Training Requirements
- Management of Patient Records

ADMINISTRATIVE RE-ORGANISATION
- Creating a Safe Environment
- Signage (Internal and External)
- Single Administrative Point
- Management of Appointments

SERVICE RE-ORGANISATION
- Four Streams of Care
- Appointments
- Fast Queue
- CCMDD or Pre-Dispensing
- Down Referral

CLINICAL MANAGEMENT SUPPORT
- Clinical Guidelines and Tools
- Clinical Stationery and Patients Records
- Training of Staff
- DR & District Clinical Specialist Team

‘ASSISTED’ SELF-MANAGEMENT
- Collaboration with Ward Based Outreach Team
- Household Visits
- Adherence Clubs and Support Groups

POPULATION HEALTH AWARENESS & SCREENING
- Health Awareness Days
- Universal Test and Treat
- Integrated School Health Team
- Ward Based Outreach Teams

MONITORING AND EVALUATION
- Waiting Time Survey
- Patient Experiences Survey
- Clinical Audit
- Performance Indicators
- Adherence to Appointments Survey
- Dashboard
Strengthening of support systems and structures outside the health facility

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
**What is Health Service Re-organisation?**

**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

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- Health awareness campaigns
- Universal test and treat
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**HEALTH SYSTEM STRENGTHENING**

- Human Resources – capacity building and scheduling
- Health Information
- Medicine supply – stock management
- Advocacy and leadership
- Equipment – essential equipment List
Health Service Re-organisation

- Administrative
- Health service
Administrative Re-organisation

- 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

THE 5-S SYSTEM

SORT

SUSTAIN

SET IN ORDER

STANDARDIZE

SHINE
Creating safe environment

‘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.

‘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

‘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.

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 to 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**
• 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 28 June 1973*

*Should be rendered as:*

1973/07/28MMA
Once a female adolescent is pregnant an adult female record should be opened

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<td>pg 58-61</td>
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<tr>
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<td>pg 62-64</td>
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female clinical record

female clinical record

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Male clinical record

ADULT MALE CLINICAL RECORD

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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
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

Separate appointment books for Chronic Care, MC&SRH, Health Support (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 patient's 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
The patients should be further **triaged** after completing the vital signs into and directed appropriately.
Designation of consulting rooms

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

<table>
<thead>
<tr>
<th>Number of patients scheduled/day</th>
<th>Number of consulting rooms to be used</th>
<th>Number of nurses to consult the patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>36-70</td>
<td>2</td>
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<td>71-105</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>106-140</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
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*

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>COLOUR</th>
<th>COLOUR INDICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibiotics</td>
<td>Orange</td>
<td>Orange</td>
</tr>
<tr>
<td>Acute Ailments</td>
<td>Neon Yellow</td>
<td>Neon Yellow</td>
</tr>
<tr>
<td>Antenatal</td>
<td>Neon Pink</td>
<td>Neon Pink</td>
</tr>
<tr>
<td>Asthma</td>
<td>Blue</td>
<td>Blue</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Light Blue</td>
<td>Light Blue</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Light Purple</td>
<td>Light Purple</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Light Pink</td>
<td>Light Pink</td>
</tr>
<tr>
<td>Heart &amp; Hypertension</td>
<td>Red</td>
<td>Red</td>
</tr>
<tr>
<td>Hiv</td>
<td>Green</td>
<td>Green</td>
</tr>
<tr>
<td>Tb</td>
<td>Yellow</td>
<td>Yellow</td>
</tr>
<tr>
<td>Pain</td>
<td>Pink</td>
<td>Pink</td>
</tr>
</tbody>
</table>
Pre-dispensing of 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 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.
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 procedures/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.
### Medication error reporting

<table>
<thead>
<tr>
<th>NO</th>
<th>PROCEDURE</th>
<th>RESPONSIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inform patient to report any medication errors noted to the CCMDD service provider on the CCMDD call centre number</td>
<td>Pick-up Point</td>
</tr>
<tr>
<td>2</td>
<td>Record and report suspected medication errors noted and log a call on the toll free number</td>
<td>Pick-up Point</td>
</tr>
</tbody>
</table>

### Handling late collection (medicines not collected within 48 hours) by patients

<table>
<thead>
<tr>
<th>NO</th>
<th>PROCEDURE</th>
<th>RESPONSIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inform CCMDD service provider of all patients who did not collect their medicines within 48 hours (2 days after) the scheduled date of collection</td>
<td>Pick-up Point</td>
</tr>
<tr>
<td>2</td>
<td>Re-contact patients (reminder call/sms) to collect medicine when notified by PuP</td>
<td>CCMDD service provider</td>
</tr>
<tr>
<td>3</td>
<td>Inform the PDoH originating health facility to do a follow-up of the patient (in the case of external PuP)</td>
<td>CCMDD service provider</td>
</tr>
<tr>
<td>4</td>
<td>Initiate patient tracing using available tracing mechanism</td>
<td>PDoH health facility</td>
</tr>
<tr>
<td>5</td>
<td>Continue to issue medicine parcels to patients who present within 14 days of their scheduled date of collection</td>
<td>Pick-up Point</td>
</tr>
</tbody>
</table>

### Patient does not collect medicines within 14 days

<table>
<thead>
<tr>
<th>NO</th>
<th>PROCEDURE</th>
<th>RESPONSIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>After 14 days of collection date record number of uncollected parcels on the manifest. Inform CCMDD service provider to uplift parcels</td>
<td>Pick-up Point</td>
</tr>
<tr>
<td>2</td>
<td>Refer patients who present after 14 days back to the PDoH originating health facility</td>
<td>Pick-up Point</td>
</tr>
</tbody>
</table>

### Issue records

<table>
<thead>
<tr>
<th>NO</th>
<th>PROCEDURE</th>
<th>RESPONSIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ensure that all patients/nominated persons to whom medicine parcels have been issued sign the delivery manifest</td>
<td>Pick-up Point</td>
</tr>
<tr>
<td>2</td>
<td>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</td>
<td>Pick-up Point</td>
</tr>
<tr>
<td>3</td>
<td>Retain original patient signed manifest</td>
<td>Pick-up Point</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Name of professional nurse</th>
<th>Month 1</th>
<th>Month 2</th>
<th>Month 3</th>
<th>Month 4</th>
<th>Month 5</th>
<th>Month 6</th>
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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

- Acute episodic care/Minor ailments (Orange)
- Chronic care (Blue)
- Preventive/Promotive care (MC&SRH) (Green)
- Health Support Services (Yellow)
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).
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.
### Acute episodic care/Minor ailments (first time-unplanned)

- 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

### Acute episodic care/Minor ailments (potentially infectious)

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)

- 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**

Sick children: diarrhoea, cough, rash
• 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

- HIV POSITIVE
  - ART ELIGIBLE
    - BOOKED FOR ART INITIATION (AFTER 12H00)
    - CHRONIC FOLLOW-UP APPOINTMENT
  - ART NOT ELIGIBLE
    - ENROL ON PRE-ART PROGRAMME
    - BOOK FOR CHRONIC APPOINTMENT
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:

- Communicable
  - HIV (Pre-ART)
  - HIV on ART
  - Tuberculosis
  - Hypertension
  - Diabetes
  - Asthma & COPD
  - Epilepsy
- Non-Communicable
  - Cardiovascular
  - Mental Health
- Chronic Diseases
Chronic care patient stream

Chronic Patient

Stable Chronic Patient

Unstable Chronic Patient

Vital Sign Station: Chronic

Stable

Nurse or Doctor Review

Unstable

Doctor Review

IF Stable

Patients for Full 6 Month Review Visits or CCMDD Assessment

Unstable

Monthly Follow-Up at Clinic

Facility Based Medicine Collection

External Adherence Clubs Pick Up

Referral to CCMDD Service Provider

Exit

IF Unstable/Not Controlled After 3 Months, Refer to Hospital
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**.
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 patient's 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**.
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)
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
• **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

<table>
<thead>
<tr>
<th>NAME AND SURNAME</th>
<th>PHYSICAL ADDRESS</th>
<th>CONTACT NUMBER</th>
<th>CONVENIENT TIME FOR CHW TO VISIT</th>
<th>LAST DATE BY WHICH MEDICATION SHOULD BE DELIVERED</th>
<th>COMMUNITY HEALTH WORKER ALLOCATED</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
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**
New process flow for MC&SRH

MATERNAL, CHILD & SEXUAL REPRODUCTIVE HEALTH

BY APPOINTMENT

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

RECEPTION

COLLECTION OF RECORDS

VITAL SIGN STATION FOR ADULTS
ASSESS, ADVISE & TREAT

CONSULTATION ROOM FOR ANTENATAL, POST NATAAL AND FAMILY PLANNING

CONSULTATION ROOM FOR CHILDHEALTH: WELL-BABY & IMMUNISATION
ASSESS & ADVISE

MEDICATION DISPENSING (PHARMACY, MEDICINES ROOM, CONSULTATION ROOM)

APPOINTMENT BOOKING

EXIT
Process flow for antenatal clients

SUSPECTED PREGNANCY

STATUS KNOWN
STATUS UNKNOWN

ACUTE EPISODIC CARE/MINOR AILMENT STREAM

NOTE: If adolescent is diagnosed as pregnant then an adult female record should be opened.

PREGNANCY CONFIRMED

RISK SCREENING

HIGH RISK IMMEDIATE

MINIMAL RISK

APPOINTMENT BOOKING

NOTE: Complete Facility patient record chart and Maternity Record (Patient Carry card)

FULL ANC CONSULTATION

TERMINATION OF PREGNANCY

REFERRAL TO HOSPITAL

APPOINTMENT BOOKING

SUBSEQUENT VISITS 20, 26, 30, 34, 36, 38 AND 40 WEEKS

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)
### Obstetric History
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 hypertension or pre-eclampsia/eclampsia?
7. Previous surgery on reproductive tract
   - (Caesarean section, myomectomy, cone biopsy, cervical cerclage)

### Current pregnancy
7. Diagnosed or suspected multiple 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)
### 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 pregnancy
- Age <16 years Age 37 years
- Rhesus isoimmunisation 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 tuberculosis
- 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 or transverse lie at term
- Extensive vulval warts that may obstruct vaginal delivery
- Pregnancy beyond 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
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

Subsequent antenatal visits

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 weeks 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
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

<table>
<thead>
<tr>
<th>Date:</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approximate gestational age (weeks)</td>
<td>&lt;14</td>
<td>20</td>
<td>26</td>
<td>30</td>
<td>34</td>
<td>36</td>
<td>38</td>
<td>40</td>
</tr>
</tbody>
</table>

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
ART for HIV-infected women
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

Re-test every 12 weeks if negative
Viral load monitoring as per guidelines
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.
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.
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.
<table>
<thead>
<tr>
<th>Patient Details Discharge (Mother)</th>
<th>Examination within 1 week (Mother)</th>
<th>Examination at 6 weeks (Mother)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Date:</td>
<td>Date:</td>
</tr>
<tr>
<td>Exam by:</td>
<td>Exam by:</td>
<td>Exam by:</td>
</tr>
<tr>
<td>Delivered at:</td>
<td>Clinic:</td>
<td>Clinic:</td>
</tr>
</tbody>
</table>

**Mother’s Name:**
- 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

**Hosp No:**
- *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

**Address:**
- *Examine the following*
  - UMAC: Temp Pulse BP

**Tel/cellphone no:**
- *Examine the following*
  - UMAC: Temp Pulse BP

**Age:**
- Pale: YES NO
- If breast feeding, nipples cracked / breast inflamed YES NO
- Uterus involuted appropriately: YES NO
- If breast feeding, are nipples cracked / breast inflamed YES NO
- *Test the following*
  - Urine normal: YES NO
  - Hb g/l (value)
  - Hb< 10g/dl YES NO

**Gravidity:**
- If C/S, is wound infected: YES NO
- *If ticks in shaded areas comment on back ⇒ Refer, if cannot treat*

**ANC complications:**
- *Test the following*
  - Sutures removed YES NO
  - CD4 Taken YES NO
  - Type of contraception

**Complications in labor:**
- Episiotomy infected: YES NO
- *If ticks in shaded areas comment on back ⇒ Refer, if cannot treat*

**Delivery route:**
- *If ticks in shaded area comment as to why on back
  - Urine normal: YES NO

**Birth weight:**
- *If ticks in shaded area comment as to why on back
  - Type of contraception

**Date of delivery:**
- *If ticks in shaded area comment on back ⇒ Refer, if cannot treat*
<table>
<thead>
<tr>
<th><strong>Patient Details</strong></th>
<th><strong>Examination within 1 week (Infant)</strong></th>
<th><strong>Examination at 6 weeks (Infant)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discharge (Infant)</strong></td>
<td><strong>Date:</strong> _____________________</td>
<td><strong>Date:</strong> _____________________</td>
</tr>
<tr>
<td><strong>Exam by:</strong> _________________</td>
<td><strong>Exam by:</strong> __________________</td>
<td><strong>Exam by:</strong> __________________</td>
</tr>
<tr>
<td><strong>Delivered at:</strong> _______________</td>
<td><strong>Clinic:</strong> ____________________</td>
<td><strong>Clinic:</strong> ____________________</td>
</tr>
<tr>
<td><strong>Infant’s name:</strong></td>
<td><strong>Infant’s name</strong></td>
<td><strong>Ask the following</strong></td>
</tr>
<tr>
<td><strong>Feeding?</strong></td>
<td><strong>EBF</strong></td>
<td><strong>FF</strong></td>
</tr>
<tr>
<td><strong>Feeding well</strong></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Problems</strong></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Excessive sleeping/Not alert?</strong></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Birth weight</strong></td>
<td><strong>Gestational age</strong></td>
<td><strong>Passed urine?</strong></td>
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<tr>
<td><strong>Jaundice:</strong></td>
<td><strong>Respiratory problems</strong></td>
<td><strong>Passed stool?</strong></td>
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<tr>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Cyanosis:</strong></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>CVS problems</strong></td>
<td><strong>Abdomen problems</strong></td>
<td><strong>Temperature (axillary)</strong></td>
</tr>
<tr>
<td>YES</td>
<td>NO</td>
<td>YES</td>
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<tr>
<td><strong>Thrush</strong></td>
<td>YES</td>
<td>NO</td>
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<tr>
<td><strong>Fontanel abnormal (anterior)</strong></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Conjunctivitis</strong></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Abdominal mass:</strong></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>If ticks in shaded area comment on back as to problem and actions taken</strong></td>
<td><strong>Umbilical cord smelly:</strong></td>
<td>YES</td>
</tr>
<tr>
<td><strong>If ticks in shaded area comment on back. Refer, if cannot treat</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vaccinate</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PCR test:</strong></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Consent given:</strong></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Bactrim prophylaxis:</strong></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Vitamin A supplementation:</strong></td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

* If ticks in shaded areas comment on back. Refer, if cannot treat.
Essential post natal care

Rapid assessment & management

Visit first week

Complete EPOC card

No risk factors identified

Follow-up at 6 weeks

Complete EPOC card

Problem

No risk

Continue with immunisations

Special health condition or risk factor

Refer to hospital

Hospital care

Combined care
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.
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