Ideal Clinic South Africa

Ideal Clinic Manual
Version 16

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INTRODUCTION AND BACKGROUND

Since the launch of the government's green paper on National Health Insurance, various reforms and initiatives are underway to improve services to be provided. Re-engineering of primary health care will therefore focus on strengthening management of facilities, upgrading infrastructure, setting and monitoring national quality standards, and establishing norms for staffing levels and skill-mix.

The 'Ideal Clinic' (IC) programme is another initiative that was started by South Africa National Department of Health (NDoH) in July 2013 as a way of systematically improving and correcting deficiencies in Primary Health Care clinics in the public sector that were picked up by the NDOH baseline standards audit in 2011-12 including the ensuing inspections of the Office of Health Standards Compliance (OHSC).

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

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

A standardized questionnaire which could be translated into a Dashboard (Ideal clinic components, sub components and elements) was developed for tracking progress in PHC's over time. The Dashboard was substantially work shopped, improved and fine-tuned since the first version. Version 15 of the dashboard is in use for the 2015/16 financial year, it is comprised of 10 components and 32 sub-components.

The next draft version, version 16 has already been compiled base on inputs received. The components and sub components remained the same but the elements were changed. The

changes made on the elements from version 15 to 16 are set out in Annexure 1. This manual was compiled using version 16 of the dashboard. See Annexure 2

PURPOSE

The Ideal clinic manual has been developed to assist managers at various levels of health to correctly interpret and understand the requirement for achieving the elements as depicted in the Ideal Clinic Dashboard. It can therefore be regarded as a reference document which guides the managers to determine the status of IC Dashboard elements in a facility.

HOW TO USE THE MANUAL

The Ideal Clinic dashboard manual is comprised of detailed steps that should be followed to achieve every element. The numbering of the steps is aligned to the numbering in the Dashboard. In some instances, a step refers the reader to a certain annexure. This implies that the relevant annexure should be used to contribute to the achievement of the element.

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

COMPONENT 1: ADMINISTRATION

1: Signage and Notices

Commitment for Ideal Clinic Elements 1-4

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

1	***Road signs informing of the location of the facility are visibly posted from the nearest arterial road up to the facility entrance***
2	***Display board reflecting the facility name, service hours, physical address, contact details and service package details at the entrance of the facility***
3	***The GUN FREE, NO SMOKING, NO ANIMALS (except for service animals) and NO HAWKERS sign is clearly sign posted at the entrance of the gate***
4	***Display board indicating a disclaimer on searches***

Process

Step 1: Familiarise yourself with the specifications for external signs. (Document to be finalised, once finalised it will be available on National Department of Health's website (www.health.gov.za)).

- Do the inspection every 6 months to check that all external signs for the facility are present and in good condition.

Step 2: In the event of having to replace new, damaged or missing signs, order signs from the sub-district/district manager through Supply Chain using the standard procurement process. See Annexure 3

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

Commitment for Ideal Clinic Elements 5-8

Signs and notices will be clearly placed throughout the facility.

5	***Photos of political leadership of health are visibly displayed***
6	***The Mission, Vision, Belief, Goals of the health facility are displayed for patients to clearly see***
7	***The organogram with contact details of the managers is displayed***
8	***All service areas including reception and toilets within the facility are clearly signposted***

Process

Step 1: Conduct an inspection of the facility every six months to ensure that all internal signs and notices for the facility are present and in a good condition. Use Annexure 4

Step 2: In the event of having to replace new, damaged or missing signs, order signs and notices through Supply Chain Management using a standard procurement process. See Annexure 3

Step 3: The signs and notices will be installed either by the supplier, district maintenance staff or facility staff.

Step 4: All signs and notices must be attached firmly to a notice board surface. Notices must be pinned to boards ONLY.

Step 5: These procedures do not include mobile notice boards.

2. Staff Identity and Dress Code

Commitment for Ideal Clinic Elements 9 -10

All staff must dress and wear protective clothing as required while on duty.

9	***There is a prescribed dress code for all service providers***
10	***All staff members comply with prescribed dress code***

Process

Step 1: Obtain the Staff Dress Code and Insignia specifications. See Annexure 5

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

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

Step 4: Schedule in-service training for all staff to orientate them on dress code. Make a record of attendance in in-service training book. See Annexure 6

Step 5: Compliance to dress code must be included in the staff performance agreements

Step 6: Each morning, check that the staff on duty are dressed correctly according to the dress code. Check that all staff is wearing name badges. See Annexure 5 for specifications of name badges.

3. Patient service Organisation

Commitment for Ideal Clinic Element 11

The facility is accessible for disabled patients.

11	***There is appropriate access for people with disabilities***

Process

Step 1: Using the Disability Access Requirement checklist make sure that the facility complies with the correct criteria. See Annexure 7

Step 2: Should your facility not comply, apply for the relevant alterations. See Annexure 3

Commitment for Ideal Clinic Elements 12 - 14

The facility must be user friendly for disabled, frail, elderly and high risk patients with efficient reception. Transport equipment will be readily available.

12	***Staff are scheduled such that help desk/reception services are available at all times***
13	***There is a process that prioritizes the frail, elderly and high risk patients***
14	***A functional wheelchair and stretcher are always available***

Process

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

Step 2: Using the process in Annexure 8 ensure that the frail, elderly and high-risk patients are prioritized.

Step 3: Schedule in-service training for ALL staff on prioritization process. Keep a record of attendance in in-service training book.

Step 4: Delegate the function of prioritization process to specified professional nurse

Step 5: Display notice in predominant language in the waiting area indicating the prioritization process for frail, elderly and high-risk patients. See Annexure 9

Step 6: Conduct random spot checks during the day to determine if frail, elderly and high-risk patients are prioritized

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

Step 8: If there are no functional wheelchairs and stretchers available at the facility, order them using the standard procurement process. See Annexure 10

Step 9: Schedule in-service training for all staff on safety procedures when transporting a patient on a wheelchair or stretcher. Make a record of attendance in in-service training book

Step 10: On a weekly basis, monitor the condition of the wheelchairs and stretchers and order repairs if required

4. Management of Patient Record

Commitment for Ideal Clinic Elements 15 - 16

A patient will have a single record containing correctly captured personal and clinical information.

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

Process

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

Step 2: Allocate a file number using the approved filing protocol. See Annexure 11

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

Commitment for Ideal Clinic Elements 17 - 20

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

17	***There is a single location for storage of all patient records***
18	***Patient records are filed in close proximity to patient registration desk***
19	***There is a standardised patient record filing system in place***
20	***The retrieval of a patient's file takes less than five minutes***

Process

Step 1: Identify a secure and lockable storage area in or near reception for the filing of patient records.

Step 2: If needed, procure a bulk storage system as per the procurement process in Annexure 3

Step 3: Using the approved patient record filing system, store patient records as per the Annexure 12

Step 4: Schedule in-service training for administrative staff on patient record filing procedures. Record attendance in the in-service training book/file

Step 6: If the identified storage area is full, identify and use a second storage area that must adhere to the approved filing system

Commitment for Ideal Clinic Elements 21 - 22

Unused records must be archived.

21	***There is an SOP for archiving and disposal of patient' records available.***
22	***The SOP for archiving and disposal of patient ' records is adhered to.***

Process

Step 1: Obtain the SOP for archiving and disposal of patient's records from www.health.gov.za ((Document to be finalised, once finalised it will be available on National Department of Health's website (www.health.gov.za)).

Step 2: Adhere to SOP

Commitment for Ideal Clinic Element 23

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

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

Process

Step 1: Using the stationery catalogue (Annexure 13), the facility admin clerk will, on a weekly basis, check that there is sufficient stationery.

Step 2: Order the required quantity using the standard procurement process as per Annexure 10

Step 3: If clinical stationery has been changed or updated, obtain the new forms from the district and discard all old copies

COMPONENT 2: INTEGRATED CLINICAL SERVICES MANAGEMENT (ICSM)

5: Clinical service provision

Commitment for Ideal Clinic Elements 24 - 25

Clinical integration is vital to ensure comprehensive clinical care. The facility will organise patient flow to provide patient with appropriate clinical care.

24	***The facility has been reorganised with designated consulting areas and staffing for acute, all chronic health conditions and preventative health services***
25	***There is an area for monitoring vital signs for the different streams of care***

Process

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

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

Step 3: Schedule in-service training for all staff on the integrated clinical services management. Record attendance in the in-service training book/file.

Step 4: Implement process flow as per plan.

Step 5: Mark out flow using colour coded foot steps to direct patients.

Commitment for Ideal Clinic Element 26

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

26 Patients' are respected at all times and in all service areas

Process

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

Step 2: The following principles should be adhered to:

- Patients should be consulted at all times behind closed doors
- Patients' medical information is confidential
- Non – clinical staff must direct patients to service areas without asking about their specific health condition

Step 3: Do spot-check to determine whether staff members respect patient s' privacy while providing services and correct identified weaknesses

Commitment for Ideal Clinic Elements 27 - 35

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

27	***TB treatment success rate is at least 85% or has increased by at least 10% from the previous year***
28	***TB (new pulmonary) defaulter rate < 5%***
29	***Anti-natal visit rate before 20 weeks gestation is at least 70%***
30	***Anti-natal patients initiated on ART rate is at least 95%***
31	***Immunisation coverage under one year (annualised) is at least 94%***
32	***Screening of patients for high blood pressure has increased by 10% since the previous financial year***
33	***Screening of patients for raised blood sugar has increased by 10% since the previous financial year***
34	***35% of patients visiting the clinic are screened for mental disorders***
35	***35% of patients visiting the clinic are treated for mental disorders.***

Process

Step 1: The record-keeping process (data collection) in the facility must feed into the DHIS data required to calculate the values of the above indicators

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

Step 3: Analyse the data and calculate to determine whether the facility is achieving the above targets

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

6. Management of Patient Appointments

Commitment for Ideal Clinic Elements 36 - 38

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

36	***An ICSM compliant patient appointment system for patients with stabilised chronic health conditionsand MCWH patients is in use***
37	***The records of booked patients are pre retrieved 72 hours before the appointment***
38	***Patient who did not honour their appointments within one week are followed up by referral to WBPHCOT to facilitate booking of new appointment***

Process

Step 1: Schedule in-service training for clinical and administration staff on patient appointment procedures. See Annexure 15. Record staff attendance in the in-service training book/file

Step 2: Conduct community dialogues led by clinic committee members to orientate all stakeholders about the clinic booking system.

Step 3: Assign appointment dates and times to patients. See Annexure 15

Step 4: As per the patient appointment, the administration staff must retrieve patient records 72 hours prior to the appointment

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

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

Step 7: Refer patients who fail to honour their appointments to the WBPHCOT for follow-up

Commitment for Ideal Clinic Element 39

Clinically stable patients with chronic conditions are provided with a two-month supply of pre-dispensed medication.

39	***Pre-dispensed medication is prepared for collection by clinically stable patients with chronic condition 48 hours prior to collection date.***

Process

Step 1: Refer to Annexure 16 on pre-dispensing of chronic medication.

Step 2: Use Annexure 17 for recording receipt of chronic medication when delivered to a patient to their home by a CHW.

7: Coordination of PHC Services

Commitment for Ideal Clinic Element 40

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

40	***There is cooperation with School health teams in providing health services to learners***

Process

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

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

Step 3: Provide feedback to the school health team. See Annexure 18 (to be finalised)

Step 4: Make provision for consulting learners referred from school health in the afternoons in line with the policy on Adolescent Friendly services.

Commitment for Ideal Clinic Element 41 - 42

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

41	***The facility refers patients with chronic but stable health conditions to WBPHCOT for support***
42	***There is evidence of two-way referral of patients between the PHC facility and WBPHCOT using prescribed stationary***

Process

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

Step 2: Supervise the WBPHCOT to enable continuity of service from the community level to the service and vice versa. See Annexure 19

Commitment for Ideal Clinic Elements 43

Continuous clinical improvement is entrenched at the facility through consultation with district clinical specialist teams.

43	***Quarterly clinical improvement report from DCST available***

Process

Step 1: DCST analyses population health indicator statistics on a quarterly basis

Step 2: DCST develops clinical improvement report for facilities where problems have been identified in collaboration with facility manager and staff

Step 3: This quarterly DCST report must be shared with ALL clinic in the district and discuss at DHMT meeting.

Step 4: The facility manager must table the report at the monthly staff meeting.

8 Clinical Guidelines and protocols

Commitment for Ideal Clinic Element 44 - 45

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

44	***The ICSM compliant package of clinical guidelines is available in all consulting rooms***
45	***All professional nurses and doctors have been fully trained on ICSM compliant package of clinical guidelines***

Process

Step 1: Do an audit of consulting rooms to check availability of ICSM compliant package of clinic guidelines. Use Annexure 20

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

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

Step 4: Schedule training for health care professionals weekly and keep attendance registers. See Annexure 21

Step 5: Conduct competency assessments regularly and submit information to district training unit

Commitment for Ideal Clinic Element 46

Clinical skills and expertise of clinicians are kept in par with latest medical intervention so that acute symptoms and signs can be alleviated thereby preventing complications and preservation of bodily functions and life.

46	***All healthcare professionals have been trained on the management of medical emergencies***

Definition: A **sudden** onset of a health condition manifesting itself by **acute** symptoms of **sufficient severity** such that the absence of immediate medical attention (including resuscitation) could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily function or death.

Process

Step 1: Determine and list all medical emergencies that are common in the health facility.

Step 2: Consult the district health specialist team and other relevant service organise inservice training.

Step 3: Allocate clinical staff members to attend yearly workshops of the identified common medical emergencies.

Step 4: Keep records of all medical emergencies that were managed in the facility and their outcome to determine future training needs.

Commitment for Ideal Clinic Elements 47 - 49

The facility will ensure that adverse events are managed appropriately and that accurate adverse event records are kept to improve patient safety

47	***The national adverse event management protocol is available***
48	***The facility's Adverse Event Management Standard Operating Procedure is available***
49	***The adverse event management records show compliance to the adverse event management protocol***

Process

Step 1: Obtain the National Adverse Event protocol from www.health.gov.za. Where there is no internet connectivity; seek hard copies from the sub-district/district. (Document to be finalised, draft available on website. Once finalised it will be available on National Department of Health's website (www.health.gov.za)).

Step 2: Using generic template develop a facility specific standard operating procedure to manage adverse events (AE) in line with the National AE protocol. (To be developed once AE protocol has been approved. Once finalised it will be available on National Department of Health's website (www.health.gov.za)).)

Step 3: Train all health care practitioners on the adverse event management protocol to ensure compliance and prevent incidence from occurring.

Step 4: The following records as stipulated in the National Protocol must be available and up to date:

- AE event register
- Monthly statistics on AE
- Minutes of monthly AE meetings

Commitment Ideal Clinic Element 50 and 51

Quality clinical care is maintained by conducting regular clinical audits.

50	***The National Clinical Audit guideline is available***
51	***Clinical audit meetings are conducted quarterly in line with the guideline***

Process

Step 1: Obtain National Clinical Audit guideline from www.health.gov.za (Document to be finalised. Once finalised it will be available on National Department of Health's website (www.health.gov.za)). Where there is no internet connectivity, obtain hard copies from the sub-district/district.

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

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

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

Step 5: Develop a report on findings with recommendations

Step 6: Provide feedback to relevant staff members

Step 7: Implement improvements as per agreed time frame

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

9 Infection Prevention and Control

Commitment for Ideal Clinic Element 52 - 54

Prevent and control infection

52	***The National Policy on Infection Prevention and Control (IPC) is available***
53	***There is a staff member who is assigned infection prevention and control role in a facility***
54	***Staff wear appropriate protective clothing***

Process

Step 1: Obtain the National Policy on Infection Prevention and Control (IPC) from www.health.gov.za. (Document is outdated to be revised. Once revised it will be available on National Department of Health's website www.health.gov.za)).

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

Step 3: Share the contents of the policy, in particular, strategic action areas with all staff members at every facility meeting

Step 4: An assigned staff member must monitor compliance of said strategic action areas and address deficiencies

Step 5: Order personal protective clothing by using the standard procurement process. See Annexure 3

Step 6: Ensure all staff wear personal protective clothing where relevant according to PPE Catalogue. See Annexure 22

Step 7: Conduct spot checks to determine if staff are complying with personal protective clothing requirements

Step 8: If staff do not comply use the progressive discipline process to address this as per the DPSA guide on disciplinary and grievance procedure.

Commitment for Ideal Clinic Element 55 - 57

Prevent and control infection

55	***The linen is clearly branded***
56	***The linen in use is clean***
57	***The linen is appropriately used for its intended purpose***

Process

Step 1: Using IPC policy, orientate all staff to Principles of IPC

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

Step 3: Dedicate a well ventilated room solely for storage of clean linen.

Step 4: Keep linen storage room under constant lock and key.

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

Step 6: Orientate all staff to appropriate use of all linen for their intended purpose at all times. See Annexure 23

Commitment for Ideal Clinic Elements 58 - 61

Prevent and control infection

58	***Waste is properly segregated***
59	***Sharps containers are disposed of when they reach 2/3 capacity***
60	***Sharps are disposed in impenetrable, tamperproof containers***
61	***Sharps containers are placed on a work surface only***

Process

Step 1: Place Waste Categorisation Schedule, see Annexure 24 in a prominent position at all waste generation points.

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

Step 3: Designate specific waste storage areas that will cater for the different types of waste without cross contamination. These areas must be lockable.

Step 4: Conduct regular spot checks at the facility waste generation and waste storage areas to determine that correct waste handling and segregation is taking place.

10. Patient Waiting Time

Commitment for Ideal Clinic Element 62 - 66

Patients are offered treatment in the quickest and most efficient time.

62	***The National policy on management of patient waiting time is available***
63	***The standard waiting time for every service area is visibly posted***
64	***Waiting time is consistently monitored using the prescribed tool***
65	***The average time that a patient spends in the facility is not longer than three hours***
66	***Patients are intermittently informed of delays and reasons for delays***

Process

Step 1: Obtain the National Policy on Waiting Time from www.health.gov.za. (Document to be finalised, once finalised it will be available on National Department of Health's website (www.health.gov.za)).

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

Step 3: Share the contents of the national policy with all staff members.

Step 4: Determine and adhere to waiting time for every service area.

Step 5: Visibly display the prescribed total patient waiting time for the facility at the reception area of the facility.

Step 6: Patients are intermittently informed of any delays and improvement measures they are taken.

Step 7: Monitor compliance with the pre-determined patient waiting time, in every service area at least monthly. See Annexure 25

Step 8: Address deficiencies as the need arises.

11: Patient Experience of Care

Commitment for Ideal Clinic Elements 67 - 70

All patients will be afforded the opportunity to voice their experience of services and such information shall be used to guide service improvement.

67	***The National Patient Experience of Care guideline is available***
68	***The results of the yearly Patient Experience of Care survey are visibly displayed in all service areas***
69	***The overall score obtained indicates that the patients are satisfied with the service provided***
70	***The results obtained from the Patient Experience of Care survey are used to improve the quality of service provision***

Process

Step 1: Obtain the National Patient Experience of Care (PEC) guideline from www.health.gov.za. (Document to be finalised, once finalised it will be available on National Department of Health's website (www.health.gov.za)).

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

Step 3: Share the contents of the national guideline with all staff members.

Step 4: Assign, in line with peer review principles (to eliminate conflict of interest) personnel members to conduct the annual survey.

Step 5: Conduct the survey as stipulated in the National PEC guideline

Step 6: Publish and display the results of the survey in line with the National PEC guideline.

Step 7: Develop and implement the quality improvement plan.

Commitment for Ideal Clinic Elements 71 and 72

Staff know how to manage complaints as per the National Complaint Management Protocol.

71	***The National Complaint Management Protocol is available***
72	***The facility's Complaint Management Standard Operating Procedure is available***

Process

Step 1: Obtain the National Complaint Management protocol from the NDOH website. www.health.gov.za

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

Step 3: Using the generic format for the complaint management process, develop facility specific standard operating procedure (SOP) to manage complaints in line with the National Complaint Management protocol. www.health.gov.za

Step 4: Share the contents of the national protocol and the facility specific SOP with all staff members

Commitment for Ideal Clinic Elements 73 - 75

All patients will be afforded the opportunity to complain about or compliment services received at the facility.

73	***Compliments/Complaints box are visibly placed at main entrance/exit***
74	***There is official complaint forms and pen placed near the complaints/compliments boxes***
75	***A standardised poster appears above the complaint/compliments box inviting patients to complain to or compliment the facility about their services***

Process

Step 1: Familiarise yourself with specifications for the complaints, compliment and suggestion box, see Annexure 26

Step 2: Order the box and the installation of the box through the standard procurement process, see Annexure 3

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

Step 4: A pen and sufficient copies of the complaints, compliments and suggestions forms must be available from the person managing the complaints box, see Annexure 27

Step 5: Print and display a notice/poster on the complaints process in the reception area, see Annexure 28

Commitment for Ideal Clinic Elements 76 - 78

All complaints will be managed as per the National Protocol.

76	***The complaint records show compliance to the Complaint Management Protocol***
77	***The monthly statistics demonstrate that complaints are resolved within 25 working days***
78	***The monthly statistics demonstrate that all complaints are resolved***

Process:

Step 1: The following records as stipulated in the National Complaint Management Protocol must be available and up to date:

- Complaint letters or completed complaint forms
- Redress letters and/or minutes of redress meeting
- Complaints register
- Monthly statistics on complaints:
    - Categories, Annexure 29
    - Statistical data, Annexure 30
- Minutes of monthly complaints meetings

Step 2: When scoring element 77 and 78, assess data from the preceding quarter.

Step 3: Monitor that timeline of 25 working days for resolution of complaints is adhered to.

- Column E of Annexure 30 must be either 100% = Green, 99% to 80% = Amber or <80% = Red

Step 4: Monitor that all complaints are resolved.

- The value of column C of Annexure 30 is obtained by calculating the totals for column B divided by the totals for column A. Scoring will be either 100% = Green, 99% - 80%= Amber, <80% = Red

COMPONENT 3: PHARMACEUTICAL AND LAB SERVICES

12: Medicines and Supplies

Commitment for Ideal Clinic Element 79 - 84

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

79	***There is at least one wall mounted minimum/maximum room thermometer in all medicine storage rooms***
80	***The temperature of medicine storage room is recorded daily***
81	***The temperature of the medicine storage rooms where medication is kept is maintained within the safety range***
82	***There is a contingency plan to manage inappropriate room temperatures***
83	***The temperature of the medicine refrigerator is recorded twice a day***
84	***The temperature of the medicine refrigerator is maintained within the safety range***

Process

Step 1: Check availability and functioning of room and refrigerator thermometers. If not available or functioning, order appropriate replacement thermometers.

Step 2: Ensure availability of monthly temperature control charts, see Annexure 31

Step 3: Allocate staff member(s) to record temperatures twice daily.

Step 4: If temperature is outside safety range for refrigerator or medicine storage room, activate the contingency plan as per SOP and Guidelines. See Annexure 32

Step 5: If refrigerator and/or air conditioner in medicine room fails, place an urgent works/procurement order for repairs/replacement. See Annexure 3

Commitment for Ideal Clinic Elements 85 - 89

Ensure consistent availability of essential medicines.

85	***There is access to an automated supply chain system for medicines***
86	***All medicines on the Essential Medicine List (EML) are consistently available.***
87	***The facility has sufficient stock to dispense chronic medication for two months***
88	***Re-order stock level (min/max) has to be determined for each item on EML***
89	***Medicines that expire within three months are returned to the depot***

Process

Step 1: Make application to the district pharmacist and provide cooperation with regard to the installation of an automated supply chain management system.

Step 2: Determine re-order levels for each item as per Good Pharmacy Practice (GPP) guidelines as agreed with the district Pharmacy and Therapeutic Committee (PTC).

- Monitor medicine room and dispensing cupboard supplies weekly to check for stock levels/expired items.
- *For facilities with computerised solutions:* Scan stocks weekly according to the software.

Step 3: Place a replenishment order to maintain the minimum/maximum medicine levels using the prescribed medicine request form. See Annexure 33

Step 4: Follow district process to submit the medicine request form. Keep copy on file.

Step 5: If order not received within two weeks then follow up with District Pharmacy by telephone and record all calls. See Annexure 34

Step 6: Follow the procedure for managing expiration of medicine. See Annexure 35

Commitment for Ideal Clinic Element 90

Ensure consistent availability of essential supplies.

90	***A list of required basic surgical supplies (consumables) indicating the re-ordering stock levels (min/max) is available***

Process

Step 1: Determine re-order levels for each item

- Monitor stock of basic surgical supplies weekly to check for stock levels/expired items. *See Annexure 36*
- *For facilities with computerised solutions:* Scan stocks weekly according to the software.

Step 2: Place a replenishment order to maintain the minimum/maximum supply levels

Step 3: Follow district process to submit the request form. Keep copy on file.

Step 4: If order not received within two weeks then follow up with District Pharmacy by telephone and record all calls. See Annexure 34

13: Management of Laboratory Services

Commitment for Ideal Clinic Element 91 - 93

Laboratory tests are requested and handled in a professional manner.

91	***The Primary Health Care Laboratory Handbook is available***
92	***Required functional diagnostic equipment and concurrent consumables are consistently available***
93	***Specimens are handled according to the Primary Health Care Laboratory Handbook***

Process

Step 1: Obtain the Primary Health Care Laboratory Handbook from www.health.gov.za. (Document to be finalised. Draft available on website. Once finalised it will be available on National Department of Health's website (www.health.gov.za)).

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

Step 3: Share the contents of the Handbook with all staff members. See Section 2 of the PHC Lab Handbook

Step 4: Ensure all necessary laboratory equipment and consumables are available. See Annexure 37

Step 5: Induct all new staff on the NHLS process on handling specimens correctly as outlined in the manual.

Step 6: Conduct weekly spot checks to make sure the process is being followed correctly.

Commitment for Ideal Clinic Element 94 and 95

Laboratory results are received and used to inform optimal patient care

94	***The laboratory results are received from the lab within the specified turnaround times***
95	***Laboratory results are filed in the patient's record within 24 hours after receiving them from the lab***

Process

Step 1: Using the tracking form check if patient laboratory results have been received manually or electronically. See Annexure 38

Step 2: If the results have not been received within the specified turn around times, follow up with the laboratory. See Annexure 34

Step 3: File all results appropriately in respective patient record/file within 24 hours of receipt.

COMPONENT 4: HUMAN RESOURCES FOR HEALTH

14: Staff Allocation and Use

Commitment for Ideal Clinic Elements 96 - 98

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

96	***Staffing needs have been determined in line with WISN.***
97	***Staffing is in line with WISN.***
98	***A dedicated facility manager must be appointed for a facility with a work-load of more than 150 patients per day and will perform at least 80% of management work per week***

Process

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

Step 2: Prepare all the information on the staff and clinic services that they will need to use.

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

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

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

Step 6: Obtain approval of the Ideal Organogram from the District Manager

Step 7: Should there be any gaps in the staffing needs, write a request to the District Manager for the posts to be created, funded and filled. Annexure 39

Step 8: If there is no progress in filling the vacant posts within 3 months, then follow-up with the District Manager and keep a record. Annexure 34

Step 9: If there is excess staff as per the approved Organogram, then advise PHC Manager for redistribution of staff.

Step 10: Participate in the recruitment and selection process as appropriate.

Commitment for Ideal Clinic Element 99

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

99	***Daily work allocation documentation is signed by all staff members***

Process

Step 1: Using the Professional Nurse Scheduling process as per the ICDM manual, draw up the work allocation schedule for Professional Nurses.

Step 2: Using the template provided, draw up the work allocation schedule for all other staff. See Annexure 40

Step 3: Print and place the schedule on the staff notice board for all staff members to see their work schedule and duties.

Step 4: Each staff member must sign the acknowledgement confirming that they are aware of their duty allocation.

Commitment for Ideal Clinic Element 100 - 102

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

100	***Leave policy is available***
101	***An annual leave schedule is available***
102	***Basic Staff records available (vacation/sick/accouchement/family responsibility leave/study leave/disciplinary action).***

Process

Step 1: Obtain the public service leave policy from the DPSA web site.

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

Step 3: Share the contents of the public service leave policy with all staff members

- Explain the important points relevant to the staff so that they understand the leave process, emphasising the need for approval prior to going on leave, unless in an emergency situation.
- Staff to sign acknowledgment indicating that they are aware of the policy and its application. See Annexure 41

Step 4: Draw up an annual leave schedule for all staff members taking into account the service needs of the facility. See Annexure 42

Step 5: Print and place the annual leave schedule on staff notice board.

Step 6: Check that every staff member has their own staff file with all relevant documentation inside. Annexure 43

Step 7: Create a new file for all new staff members within one week of commencement of duty.

- If a staff member is transferred to your clinic, request their staff file from their previous place of employment.
- If a staff member is transferred from your clinic, send their staff file to the clinic they will be transferring to.

Step 8: The Leave Register must be updated and completed when staff member takes a leave of absence for any reason.

15: Professional Standards and Performance Management Development (PMDS)

Commitment for Ideal Clinic Element 103

Entrench goal oriented performance by staff members through appropriate appraisals.

103	***There is an individual Performance Management Agreement for each staff member***

Process

Step 1: Obtain the PMDS policy from the DPSA web site.

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

Step 3: Share the contents of the PMDS leave policy with all staff members

Step 4: Ensure that each staff member has an approved and signed job description available.

Step 5: Use the prescribed PMDS templates to develop an individual Performance Management Agreement (PMA). See Annexure 44

- Ensure that the performance goals of the facility are reflected within the key PMA of individual staff members
- PMA to be signed by the individual staff member and the facility manager after discussion and agreement in person.
- Submit signed original copies to District Office by 15 April.
- Copy of signed PMA to be kept in the individual personnel files.

Step 6: Performance appraisal to be conducted quarterly using the PMDS evaluation templates (Annexure 45)

Commitment for Ideal Clinic Element 104 - 105

Create an environment that supports staff development for personal and professional growth to deliver quality services.

104	***Continued staff development needs have been determined for the current financial year and submitted to the district manager***
105	***Training records reflect planned training is conducted as per the district training programme***

Process

Step 1: Conduct a skills audit for all staff members using Annexure 46

Step 2: Develop a staff development and training plan based on the skills audit and service needs.

- Submit to District Manager by 15 April. See Annexure 47

Step 3: Obtain approval and necessary funding for staff development and training plan.

Step 4: Once accepted for training, staff members should be released for the identified training taking into consideration the facility staffing and service needs.

Step 5: Record all training in the Human Resource database (Skillsmart)

Commitment for ideal Clinic Element 106 and 107

All staff have relevant knowledge and understanding of the disciplinary and grievance procedures.

106 The disciplinary procedure is available
107 The grievance procedure is available

Process

Step 1: Obtain the public service disciplinary and grievance procedures from the DPSA web site.

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

Step 3: Share the contents of the disciplinary and the grievance procedures with all staff members

Step 4: All staff must sign acknowledgement that they have been informed of the procedures and understand it. See Annexure 48

Commitment for Ideal Clinic Elements 108 - 109

Conduct a yearly staff satisfaction survey and use the results to improve the working environment.

108	**Staff satisfaction survey is conducted annually**
109	**The results of the staff satisfaction survey is used to improve the work environment**

Process

Step 1: Using the national staff satisfaction survey template, the district Human Resource Management unit must conduct the yearly staff satisfaction survey. See Annexure 49

Step 2: District Human Resource Unit must analyse the results and present to DHMT with recommendations for improvement. See Annexure 50

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

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

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

16: Access to Medical, Mental Health, and Allied Health Practitioners

Commitment for Ideal Clinic Element 110 - 119

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

110	***Patients have access to a medical practitioner***
111	***Patients have access to oral health services***
112	***Patients have access to occupational therapy services***
113	***Patients have access to physiotherapy services***
114	***Patients have access to diabetic services***
115	***Patients have access to social work services***
116	***Patients have access to radiography services***
117	***Patients have access to ophthalmic service***
118	***Patients have access to mental health services***
119	***Patients have access to speech and hearing services***

Process

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

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

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

Step 4: Make suitable arrangements for referral of patients to services that cannot be provided at the facility

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COMPONENT 5: SUPPORT SERVICES

17: Finance and Supply Chain Management

Commitment for Ideal Clinic Element 120 - 122

Ensure the availability of key resources at all times through the application of good financial management and supply chain practises.

120	***The facility manager has appropriate financial delegation***
121	***The facility manager is involved in determining the budget of the facility***
122	***The budget and actual expenditure of the facility is available***

Process

Step 1: District manager to ensure that the facility managers has the capacity for managing the finances in line with the delegation.

Step 2: District finance manager to set up the facility as a cost centre

Step 3: Obtain a signed financial delegation letter from the district.

Step 4: Ensure that you are part of the discussion at district level that will result in the facility's budget allocation

Step 5: Allocate financial resources in line with the facility needs.

Step 6: Develop control measures for rational budget utilisation and expenditure.

Step 7: Using the monthly expenditure report as received from sub-district, compare the report to the monthly commitment register you have in your records for the relevant month. See Annexure 51

Step 8: Participate in the monthly sub-district/district expenditure review meetings

Step 9: Query any differences/discrepancies in expenditure balances with the sub-district/district and make relevant submission for correction of the

discrepancies. After the corrections have been authorised, reallocate the funds according to budget pressures.

Commitment for Ideal Clinic Element 123 - 125

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

123	***The facility has access to an automated supply chain system for general supplies***
124	***Facility manager uses the supply chain system to ensure adequate replenishment of supplies***
125	***Delivery of supplies is consistent with terms and conditions of the relevant contract (including set turn-around times)***

Process

Step 1: The district supply chain management (SCM) unit to ensure that the facility has access to the automated system.

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

Step 3: Replenish item as indicated by the system.

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

Step 5: Keep all source documents safely.

18: Hygiene and Cleanliness

Commitment for Ideal Clinic Element 126 - 131

The entire facility is clean at all times.

126	***There are sufficient cleaners***
127	***All cleaners have been trained on cleaning***
128	***All work completed is signed off by cleaners***
129	***Cleaning materials are available***
130	***Intensive cleaning of a facility is conducted during the least busy times***
131	***All service areas are clean***

Process

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

Step 2: Ensure that cleaners have been appropriately trained and are fully aware of their duties. This includes orientation of new cleaners. See Annexure 52

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

Step 3: Identify additional training needs of cleaners and schedule relevant in-service training. Annexure 53

Step 4: Maintain records of training of each cleaner. Annexure 54

Step 5: Obtain the prescribed list of non-negotiable cleaning materials. Annexure 55

Step 6: Order the required cleaning material in line with the facility minimum and maximum quantities. Annexure 10

Step 7: Ensure that cleaning is in-line with expected standards and that cleaners take responsibility for their allocated areas through appropriate supervision and sign-off on check list. Annexure 56

- Schedule the intensive cleaning times so that they do not clash with the busy times of the Facility. Annexure 57
- Conduct daily inspections of the service areas of the facility using the Cleaning Inspection Check list. Annexure 58
- If any areas are not clean, discuss with the relevant cleaner and get them to clean again.
- Instruct cleaners to inform the facility manager of any repairs required immediately.

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

Commitment for Ideal Clinic Element 132

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

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

Process

Step 1: District management to ensure that all clinics have running water and access to stored water for back-up

- If there is a break in the normal supply of clean running water, immediately fill in a works order, following the procedure. See Annexure 3

Step 2: Conduct a weekly inspection of the water storage vessel to ensure the correct quantity and quality of water.

Step 3: Conduct a weekly inspection of all consumables to ensure the correct quantity is available.

Step 4: Order the required toilet paper, liquid hand wash soap and disposable hand paper towels in line with the facility minimum and maximum quantities. Annexure 10

Step 5: Ensure the availability of toilet paper, liquid hand wash soap and disposable hand paper towels in the appropriate areas

Commitment for Ideal Clinic Element 133 and 134

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

133	***Sanitary disposal bins with functional lids are available***
134	***General waste bins are lined with appropriate coloured plastic bags and have functional lids in all hand washing areas and consulting rooms***

Process

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

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

- Sanitary disposal bins must be lined with red bin liners
- General waste bins must be lined with transparent or black bin liners

Step 3: Place the sanitary and general waste bins in the appropriate areas.

- Waste bins must never be more than three quarters full
- Waste bins must be emptied at least twice daily

Step 4: Conduct weekly checks on the status of the sanitary disposal bins and the general waste bins to ensure compliance to the infection control measures. Non-functional sanitary disposal bins and general waste bins (broken and/or damaged) must be replaced by ordering new ones. See Annexure 10

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

Commitment for Ideal Clinic Element 135

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

135 All toilets are always intact and functional

Process

Step 1: Obtain checklist for functional toilet status. (Annexure 61)

Step 2: Conduct a weekly check on the toilets in your facility to see that they are intact and functional.

Step 3: If the toilets are not functional then demarcate the toilet as “Not Working- Do Not Use”

Step 4: Place a requisition for repair. See Annexure 3

Commitment for Ideal Clinic Elements 136 and 137

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

136	***The exterior of the facility is clean***
137	***Vegetation is well trimmed***

Process

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

Step 2: Ensure that groundsmen have been appropriately trained and are fully aware of their duties. This includes orientation of new groundsmen. See Annexure 62

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

Step 3: Identify additional training needs of groundsmen and schedule relevant in-service training. Annexure 63

Step 4: Maintain records of training of each groundsmen. Annexure 64

Step 5: Inspect the exterior once a week to ensure that it is clean and that the vegetation is well trimmed, using Checklist for Exterior Areas and vegetation trimmed. Annexure 65

Step 6: Instruct the cleaners/groundsman to clean the identified areas.

Step 7: Request minor repairs. Annexure 3

Step 8: Inspect the vegetation around the facility once a week to ensure that it is well trimmed.

- If not, instruct the groundmen to clean up identified areas.

Commitment for Ideal Clinic Element 138 - 140

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

138	***Waste is stored in access-controlled rooms***
139	***A signed waste removal service level agreement between the health department and the service provider is available***
140	***Waste is removed, regularly in line with the contract***

Process

Step 1: Obtain the SOP for waste management. Annexure 66

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

Step 3: Share the contents of the waste management SOP with all staff members

Step 4: All staff must sign acknowledgement that they have been informed of the waste management SOP. See Annexure 67

Step 5: Train all staff on the importance of waste handling, segregation and the purpose of the colour categorisation.

Step 6: Place Waste Categorisation Schedule (Annexure 24) in the dirty utility room.

Step 7: Conduct spot checks at the facility waste generation points to determine that correct waste handling and segregation is taking place.

- If you find that the approved standards for waste management are not being followed, instruct and re-train staff on waste segregation and management.

Step 8: Ensure all waste are stored in the appropriate general and medical waste storage areas.

- If designated area is not available or conforming to required standard, place a works order. See Annexure 3

Step 9: Obtain and keep a copy of the signed waste removal SLA from the sub-district/district

- Read and understand the SLA so you are aware of the service delivery requirements that the waste removal service provider must comply to.

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

Step 11: Record each incident of non-compliance and escalate to the District Office.

19: Security

Commitment for Ideal Clinic Element 141 - 144

Patient and staff safety is assured at all time.

141	***Perimeter fencing is intact and complies with South African Police Service standards***
142	***Separate lockable pedestrian and vehicle gates are available***
143	***Adequate security lighting of the perimeter is available***
144	***There is a standardised security guard room***

Process

Step 1: Obtain copy of the Infrastructure standards (IUSS) for external security measures.

Step 2: Inspect the facility with the district infrastructure manager to determine gaps in security infrastructure

- If gaps are identified, place a works order. Annexure 3

Step 3: Conduct an inspection of the facility with the Facility Security service provider every two weeks to determine the status of the security and safety of the facility using the checklist. Annexure 68

- If gaps are identified, place a works order. Annexure 3

Step 4: Keep a copy of each inspection and actions undertaken.

Commitment for Ideal Clinic Element 145

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

145	***A signed copy of the service level agreement (SLA) between the security company and the provincial department of health is available and understood by PHC facility management and staff.***

Process

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

- Read and understand the SLA so you are aware of the service delivery requirements that the security service provider must comply with.

Step 2: Orientate your staff on the terms of the SLA

Step 3: Monitor if security services complies with the requirements of the SLA.

- At the fortnightly meetings with the security service provider, discuss performance, challenges, non-compliances and corrective action required for the next two weeks. Keep records of these meetings and file in the Security file.

Step 4: Record each incident of non-compliance, discuss with security personnel and service provider to institute corrective action.

Step 5: Escalate repeated incidents of non-compliance to the District Office.

Commitment for Ideal Clinic Element 146

The facility will maintain a secure environment using agreed upon functional equipment

146	***Functional security equipment is available in security guard room as per Service Level Agreement***

Process

Step 1: Using the essential security equipment list, Annexure 69, identify any omissions.

Step 2: Ensure that the service provider provides the prescribed equipment as per SLA.

Step 3: For items that the facility is responsible to provide (eg. Tables, chairs, lighting), procure the equipment using the appropriate procurement process. Annexure 10

Step 4: Conduct a weekly review of the records relating to the functionality of the security equipment.

Step 5: Advice the Facility Security service provider that they must respond to the deficiencies within the turn around time prescribed in the SLA.

Step 6: Escalate to sub-district/district manager in writing if corrective action is not timeously taken.

Commitment for Ideal Clinic Element 147

The security staff, in line with the National Security Act, will control the access of dangerous items on the premises to maintain a safe and secure environment.

147	***Prohibited items appropriately controlled and accounted for before access is granted***

Process

Step 1: Using the list of prohibited items (See Annexure 70) place appropriate signage (Annexure 71) of prohibited items at the entrance of the security guardroom and at strategic service points of the facility.

Step 2: Prohibited items must be logged in the register, placed in the designated lockers and the key to be taken by the patient.

Step 3: Conduct random spot checks to confirm that the security guards are controlling access of prohibited items.

Step 4: Advice the Facility Security service provider that they must respond to the deficiencies within the turn around time prescribed in the SLA.

Step 5: Escalate to sub-district/district manager in writing if corrective action is not timeously taken.

20: Disaster Management

Commitment for Ideal Clinic Element 148

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

148	***Functional fire fighting equipment is available and accessible***

Process

Step 1: Check that the facility is in possession of a valid certificate of compliance from the local municipal fire department.

- If not, obtain the certificate through the district manager.
- Should the fire department point out compliance weaknesses, address these immediately.

Step 2: Obtain a list of the essential fire fighting equipment (Annexure 72) that should be in your facility.

Step 3: Conduct weekly inspections and ensure that equipment is functional.

- Keep record of inspections conducted that indicate the status of the equipment. Annexure 73
- If any gaps, request the fire fighting equipment service provider to supply and install the necessary equipment. Complete procurement and a works-order. Annexure 3 and Annexure 10
- Should the service provider declare a piece of equipment unserviceable and the item is declared obsolete, procure new equipment. Annexure 10

Step 4: Obtain the SLA including the maintenance plan for the fire fighting equipment.

Step 5: Contact the service provider to confirm the date for the servicing and compliance check by logging the call in the register.

- The Service provider must record the result of the service in the register once the service is completed.
- Inspect the register once a month to ensure that the service is carried out timeously.

- If an item/s of fire fighting equipment has been used, immediately contact the service provider to restore functionality for future use.

Step 6: Escalate to sub-district/district manager in writing if corrective action is not timeously taken.

- Do regular follow ups until the issue is resolved

Commitment for Ideal Clinic Element 149 and 150

The clinic is at all times ready for emergency evacuation.

149	***Emergency evacuation procedure practiced annually***
150	***Deficiencies identified during the emergency evacuation, are addressed***

Process

Step 1: Developed emergency evacuation plan.

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

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

Step 3: Debrief and feedback to staff, patients and stakeholders.

Step 4: Draw up an emergency evacuation practice report and file.

Step 5: Plan and implement remedial action within two weeks

Step 6: Rerun the evacuation practice if necessary

Commitment for Ideal Clinic Element 151 and 152

The clinic is at all times to manage outbreaks and disasters.

151	***Intersectoral outbreaks/disaster management plan is available***
152	***Annual review and staff awareness of the outbreak/disaster management plan***

Process

Step 1: Obtain the outbreak/disaster plan from the sub-district/district office.

Step 2: Identify all role players involved in the intersectional outbreak/disaster response team.

Step 3: Ensure that a list of relevant contact details of role players is readily available.

Step 4: Schedule and discuss the facility outbreak/disaster plan with all staff every six months during a staff meeting.

Step 5: Assign/designate roles to staff.

Step 6: Ensure all required equipment is labled and available.

COMPONENT 6: INFRASTRUCTURE AND SUPPORT SERVICES

21: Physical Space and Routine Maintenance

Commitment for Ideal Clinic Element 153

The facility adequately accommodates all relevant services and staff.

153 Clinic space accommodates all services/disciplines and staff

Process

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

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

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

Commitment for Ideal Clinic Elements 154 and 155

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

154	***The clinic has access to a functional District infrastructure maintenance hub***
155	***Routine maintenance of the infrastructure is conducted***

Process

Step 1: Compile a list of major infrastructure repairs and maintenance work required.

Step 2: Make application for major repairs and maintenance work using Annexure 3

Step 3: Follow up with the district manager within one week of submitting major repair/ maintenance request if request has not been honoured.

Step 4: All infrastructure major repair and maintenance work done at the PHC facility will be recorded in the Infrastructure Repair Logbook.

Commitment for Ideal Clinic Elements 156

Minor repairs are promptly carried out immediately to allow safe and efficient patient care at all times.

156 Minor repairs are promptly carried out

Process

Step 1: As soon as items for repair are identified, complete and submit a works order or log call to the maintenance hub.

Step 2: If no action has been taken within 24 hours, escalate to sub-district/district.

Step 3: All minor repair work done at the PHC facility will be recorded in the Infrastructure Repair Logbook.

22: Essential Equipment and Furniture

Commitment to Ideal Clinic Element 157 and 158

Appropriate, functional furniture and essential equipment is available in every consulting room, as per the ICDM manual.

157	***Consulting room furniture is available and functional in every consulting room***
158	***Essential equipment is available and functional in every consulting room***

Process

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

- Basic consulting room furniture Annexure 74
- Essential Equipment Annexure 75

Step 2: Using the lists for furniture and essential equipment required in the consulting room, conduct a quarterly stock taking and ensure that all the items are available using the standard procurement procedure. Annexure 10

Step 3: Where there is no response make follow up with sub-district/district within 7 working days.

Commitment to Ideal Clinic Elements 157-160

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

159	***Resuscitation room is equipped with functional basic equipment for resuscitation***
160	***Emergency trolley is cleaned and filled up at least daily and after being used***
161	***There is sterile emergency delivery pack***
162	***Equipment for minor surgery is available***

Process

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

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

- Resuscitation room: Monthly Annexure 76
- Emergency trolley: Daily Annexure 77
- Sterile emergency delivery pack: Daily Annexure 78
- Equipment for minor surgery: Daily Annexure 79

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

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

Commitment for Ideal Clinic Element 163

Oxygen must be consistently available to patients when needed.

163 Oxygen supply is available

Process

Step 1: The facility's mobile oxygen cylinder must be fitted with a functional gauge at all times.

Step 2: The facility's mobile oxygen cylinder must at all times be filled to the required level.

Step 3: Designate a staff member to ensure on a daily basis that the oxygen supply is sufficient.

Step 4: Using the check sheet Annexure 80, on a daily basis ensure that the oxygen level is as prescribed.

Step 5: Should the oxygen in the cylinder be below the prescribed level contact your service provider to have the cylinder refilled or exchanged with a full one.

Commitment to Ideal Clinic Elements 164 and 165

All clinical facility staff must be trained in resuscitation procedures.

164	***There is a protocol on resuscitation in a health facility***
165	***PHC facility staff are familiar with resuscitation procedures***

Process

Step 1: All facilities must have a protocol on resuscitation.

Step 2: Ensure that all clinical staff have access to and are familiar with the protocol on resuscitation. See Annexure 81

Step 3: Determine resuscitation training needs of clinic staff members.

Step 4: Should any staff require resuscitation training, arrange this using the district training plan.

Commitment to Ideal Clinic Element 166

The facility's internal and external environment is tidy, neat and clean.

166 Redundant and non-functional equipment is promptly removed from the facility

Process

Step 1: If there are any items of equipment found to be redundant or beyond repair, notify the district, and dispose of these items using the Asset Disposal Form. Annexure 82

Step 2: Update asset register accordingly.

23: Bulk supplies

Commitment for Ideal Clinic Elements 167 - 169

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

167	***There is constant supply of clean, running water to the facility***
168	***There is emergency water supply in the facility***
169	***Water supply is quarterly checked for quality***

Process

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

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

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

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

Step 4: Using the district protocol for ensuring safe drinking water, the facility manager must ensure that the facility's water supply is safe. This entails routine water quality inspections conducted by the environmental health department of the municipality.

Step 5: After each inspection, request a copy of the water quality audit report from the environmental health department of the municipality. This report should include the corrective action taken where necessary.

Commitment for Ideal Clinic Element 170 and 171

Facilities must have uninterrupted electricity supply.

170	***There is a functional back-up electrical supply***
171	***The back-up electrical power supply is regularly checked to determine its functionality***

Process

Step 1: In cooperation with the district infrastructure unit ensure that a functional generator is installed at the facility.

Step 2: Assign a staff member to check the fuel levels on a weekly basis and after every use.

Step 3: Report and correct any defects.

Step 4: Make sure that the emergency contact number for generator maintenance is prominently displayed on the facility notice board (together with other emergency numbers of essential services) on the Emergency Contact Numbers- Essential Services list

Commitment for Ideal Clinic Element 172

Removal of sewerage must be efficiently and safely done to ensure a safe and hygienic facility.

172 The sewerage system is functional

Process

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

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

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

24: ICT Infrastructure and Hardware

Commitment for Ideal Clinic Element 173

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

173 There is a functional telephone system in the facility

Process

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

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

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

Commitment for Ideal Clinic Element 174

Facilities must have a functional public address system in place to announce emergencies and notifications.

174 A functional public address system is available

Process

Step1: Should the facility not have a public address system in place order one using relevant procurement procedure. Annexure 3

Step 2: Train the relevant reception staff and emergency coordinator in the protocols and correct use of the public address system.

Step 3: Designate a staff member to test and ensure the functionality of the system on daily basis.

Step 4: Keep record of the status of the status.

Step 5: In the event that the public address system is not functional log a call with the maintenance hub.

Commitment for Ideal Clinic Element 175 - 177

Functional ICT equipment (computer, printer and e-mail) must be available, at all times.

175	***There is a functional computer***
176	***There is a functional printer connected to the computer***
177	***There is web access***

Process

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

Step 2: Update the asset register accordingly

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

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

Step 5: Ensure that the facility has internet access

COMPONENT 7: HEALTH INFORMATION MANAGEMENT

25: District Health Information System (DHIS)

Commitment for Ideal Clinic Element 178 - 182

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

178	***Facility performance in response to burden of disease of the catchment population, is displayed and is known to all clinical staff members***
179	***Current disease trends inform prioritization of health care plans***
180	***District Health Information Management System policy available***
181	***Relevant DHIS registers are available and are kept up to date***
182	***There is a functional computerized patient information system***

Process

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

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

Step 3: Facility staff must be conversant with the district health information system management policy. Obtain the policy in hard copy or from the NDoH website and orient staff on its contents.

Step 4: Data generate by the facility must be recorded in the approved PHC registers.

Step 5: In cooperation with national, provincial and district health departments, install and train staff on the use of a computerized patient information system.

COMPONENT 8: COMMUNICATION

26: Internal communication

Commitment for Ideal Clinic Element 183

Quarterly performance review meetings are attended by all facility managers to discuss the performance of the facilities and plan corrective actions to improve facility performance.

183 There are district quarterly facility performance review meetings

Process

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

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

- The facility manager must schedule a meeting with the facility staff one week before to prepare the facility's presentation

Step 3: Using the relevant provincial template prepare the PowerPoint presentation.

Step 4: Deliver the facility's presentation and answer all questions.

Step 5: Discuss what actions will be taken to achieve set targets and what changes need to be made within the facility. Make notes during the discussion.

Step 6: Make notes of activities and challenges in other facilities and any good practices that you could replicate in your own facility.

Step 7: File a copy of the presentation electronically and make sure that computer content is backed up appropriately.

Commitment for Ideal Clinic Element 184

The facility must meet at least once a month to discuss the clinic's operations, performance, staff and general issues to ensure smooth functionality at all times.

184 There is at least a monthly meeting within the facility

Process

Step 1: Draw up a monthly meeting schedule.

Step 2: Include monthly meeting dates on the Annual Facility Calendar. Annexure 42

Step 3: Inform staff of the dates and place the monthly meeting schedule for the year on the staff notice board. All staff must be available for these meetings.

Step 4: Develop an agenda for the meeting. Annexure 83

Step 5: All staff who attended the meeting must sign the attendance register. Annexure 84

Step 6: Designate a staff member to take minutes.

Step 7: Minutes of the meeting will be available within three working days after the meeting and will be filed electronically in month / date order. Minutes are available for all staff to read. Annexure 85

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

Commitment for Ideal Clinic Element 185

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

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

Process

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

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

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

Step 4: Get all staff members to sign the acknowledgement form. Attach this to the back of the new policy or notice and file the document. Annexure 21

Step 5: If there are further questions regarding the policies and notices seek relevant answers from the relevant source or your Local Area Manager.

27: Community Engagement

Commitment for Ideal Clinic Elements 186 and 187

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

186	***There is a functional clinic committee***
187	***Contact details of clinic committee members are visibly displayed***

Process

Step 1: Using National Clinic Committee Guidelines (www.health.gov.za) understand the roles, responsibilities and activities of the clinic committee as well as how to get a functional clinic committee established. (Document to be finalised, once finalised it will be available on National Department of Health's website (www.health.gov.za)).

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

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

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

Step 4: In cooperation with the office of the MEC obtain nominations of clinic committee members and complete the election process.

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

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

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

- Develop a schedule of monthly meetings.
- Request training for clinic committee members from the district.
- Attend clinic committee meetings, ensure that agenda developed, register is kept and minutes are taken. Annexure 83 / Annexure 84 / Annexure 85.
- Follow up actions arising out of clinic committee meetings.

Commitment for Ideal Clinic Element 188

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

188	***There is an annual open day facilitated by the clinic committee***

Process

Step 1: Arrange a meeting with the clinic committee to discuss community engagement activities and plan for open days. See an example of suggested services and activities for an Open Day. Annexure 86

Step 2: Log dates agreed on with clinic committee in an annual calendar to be displayed on the notice board. Annexure 42

Step 3: Designate a staff member to organise and market the Open Day with the clinic committee.

Step 4: In cooperation with the clinic committee seek support from relevant sources.

Step 5: On the day of the event in cooperation with the clinic committee, oversee the set up and activities including various health screening.

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

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

COMPONENT 9: DISTRICT HEALTH SYSTEM SUPPORT

28: District Health Support

Commitment for Ideal Elements 189 and 190

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

189	***There is a health facility operational plan in line with district health plan***
190	***The Permanent Perfect Team for Ideal Clinic Realisation and Maintenance (PPTICRM) visits the clinic at least twice a year to record the Ideal Clinic Realization and Maintenance status and to correct weaknesses***

Process

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

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

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

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

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

29: Emergency patient transport

Commitment for Ideal Clinic Elements 191 and 192

The facility must have access to emergency transport.

191	***There is a pre-determined ambulance response time to the facility.***
192	***Ambulances respond in time with the pre-determined response time.***

Process

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

Step 2: Keep a register of actual emergency transport response time Annexure 87

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

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

Step 4: If no response to the follow-up has been received from the sub-district/district office within 7 days then escalate the query to the next level.

30: Referral System

Commitment for Ideal Clinic Element 193 - 197

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

193	***The National Referral Policy is available***
194	***The facility's Standard Operating Procedure (SOP) for referrals is available and sets out clear referral pathways***
195	***There is a referral register that records referred patients***
196	***Referral records indicate feedback from destination facilities***
197	***There is a standard National Referral form that is used by all for referring patients***

Process

Step 1: Obtain a copy of the National Referral Policy (www.health.gov.za). (Document to be finalised, once finalised it will be available on National Department of Health's website (www.health.gov.za)).

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

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

Step 4: Make a list of all the available referral pathways and display it. See Annexure 88 as an example.

Step 5: Keep sufficient stock of standardised referral forms. Annexure 89

Step 6: Complete the patient referral form when a patient is referred and a copy in the patient file.

Step 7: Keep record of all referred patients in the referral register. Annexure 90

Step 8: Obtain feedback from referral facilities once the patient has been attended to. Record this in the referral register and patient's file.

COMPONENT 10: Partners and Stakeholders

31: Partners Support

Commitment for Ideal Clinic Elements 198 - 200

Implementing partners must support the activities of the facility.

198	***The up to date list (with contact details) of all implementing health partners that support the facility***
199	***The list of implementing health partners shows their areas of focus and business activities***
200	***Implementing health partners perform in relation to their focus area and business activities***

Process

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

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

Step 3: Schedule a meeting with all identified health partners to discuss and agree on their contribution to support the facility.

Step 4: Develop and sign a strategy (memorandum of understanding) on how the support is going to be carried out.

Step 5: Establish reporting framework for all implementing partners to the facility and district using reporting template. Annexure 91

Step 6: Organise regular meeting to share feedback on the support provided.

32: Multi-sectoral collaboration

Commitment for Ideal Clinic Elements 201 - 209

The MoU's will be available at the facility and will be read and understood by the Facility manager and staff.

201	***There is an official Memorandum of Understanding between the PDoH and SAPS available.***
202	***There is an official Memorandum of Understanding between the PDOH and the Department of Education available.***
203	***There is an official Memorandum of Understanding between the PDOH and Department of Social Development available.***
204	***There is an official Memorandum of Understanding between the NDOH and Home Affairs available.***
205	***There is an official Memorandum of Understanding between the PDOH and Department of Public works available.***
206	***There is an official Memorandum of Understanding between the district management and Cooperative Governance and Traditional Affairs (CoGTA).***
207	***There is an official Memorandum of Understanding between the PDOH and the Department of Transport.***

Process

Step 1: Obtain a list from the sub-district/district of contact details of all the relevant government department.

Step 2: Obtain a copy of the relevant MoU's from the sub-district/district.

Step 3: Share the contents of the MoU.

Step 4: Staff are to sign a register that they have read and understand each MoU. See Annexure 41

Step 5: Staff to sign acknowledgment indicating that they are aware of the MoUs and its application. See Annexure 92

Step 6: The facility must keep record and provide regular feedback to the sub-district/district on implementation of these MoUs including consistent lack of cooperation.

ANNEXURES

ANNEXURE 1- Changes Made to Version 15 of the Ideal Clinic Manual

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

CHANGES MADE TO VERSION 15 OF THE IDEAL CLINIC DASHBOARD

1. **Deleted the following elements:**

Element 144: Registers for access control are available and up to date
Element 145: Major infrastructure repairs are carried out as planned
Element 192: There is effective planned patient transport to and from the referral hospitals
Element 195: Referral pathways are clearly determined
Element 199: Analysis of referral data is conducted to identify service delivery gaps
Element 207: There is an official Memorandum of Understanding between the PDOH and Local Government
Element 208: There is an official Memorandum of Understanding between PDOH and Department of Water and Sanitation
Element 212: There is an official Memorandum of Understanding between the District management and relevant NGOs

2. **Added the following element:**

Element 122: Facility manager uses the supply chain system to ensure adequate replenishment of supplies
Element 34: 35% of patients visiting the clinic are screened for mental disorders
Element 35: 35% of patients visiting the clinic are treated for mental disorders

3. **Changed the statement of the following element:**

a. Elements 92 read: “The PHC laboratory results are received from the lab within 72 hours” changed to

"The PHC laboratory results are received from the lab within the specified turnaround times"

b. Element 194 read "The facility's Standard Operating Procedure for referrals is available" changed to
"The facility's Standard Operating Procedure for referrals is available and sets out clear referral pathways"

4. Replaced the word 'client' with 'patient'

5. Changed the order of some of the elements to ensure logic flow

6. Changes in responsibility

Element: Specimens are handled according to the National Health Laboratory Services Handbook. Responsibility changed from NDoH to Health Facility

7. Changes in weights

NO	Element	Current weight	New weight
80	There is a contingency plan to manage inappropriate room temperatures	V	I
85	The facility has sufficient stock to dispense chronic medication for 2 months	V	E
86	Re-ordering stock levels (min/max) is determined for each item on the Essential Medicine List	V	E
90	Specimens are handled according to the National Health Laboratory Services Handbook	V	E
92	The PHC laboratory results are received from the lab within 72 hours	V	E
108	Clients have access to a medical practitioner	V	E
109	Clients have access to oral health service	E	I
114	Clients have access to radiography services	E	I
115	Clients have access to ophthalmic service	V	I
117	Clients have access to speech and hearing services	E	I
157	Essential equipment is available and functional in every consulting room	V	E
164	Equipment for minor surgery is available	V	E
167	There is emergency water supply in the facility	V	E

ANNEXURE 2- Ideal Clinic Realisation and Maintenance Dashboard

National Core Standards	Component	IDEAL CLINIC REALISATION AND MAINTENANCE DASHBOARD								
		Sub Component		ELEMENTS	Weight	MM	Performance	Level of responsibility.	Comments
DOMAIN 1: PATIENT RIGHTS	1. Administration	1. Signage and Notices: Monitor whether there is communication about the facility and the services provided							
			1	Road signs informing of the location of the facility are visibly posted from the nearest arterial road up to the facility entrance	I	😐		P	
			2	Display board reflecting the facility name, service hours, physical address, contact details and service package details at the entrance of the facility	I	😐		D	
			3	The GUN FREE, NO SMOKING, NO ANIMALS (except for service animals) and NO HAWKERS sign is clearly sign posted at the entrance of the gate	I	😐		D	
			4	Display board indicating a disclaimer on searches	I	😐		D	
			5	Photos of political leadership of health are visually displayed	I	😐		D	
			6	The Mission, Vision, Belief, Goals of the health facility are displayed for patients to clearly see	I	😐		D	
			7	The organogram with contact details of the managers displayed	I	😐		HF	
			8	All service areas including reception and toilets within the facility clearly signposted	I	😐		HF	
		2. Staff identity and dress code: Monitor whether staff uniform, protective clothing and mode of staff identification are according to policy prescripts							
			9	There is a prescribed dress code for all service providers	I	🕮		P	
			10	All staff members comply with prescribed dress code	I	?😐		HF	
		3. Patient service organization: Monitor the processes that enable responsive pateints service.							
			11	There is appropriate access for people with disabilities	V	😐		D	
			12	Staff are scheduled such that helpdesk/reception services are available at all times	I	😐🕮		HF	
			13	There is a process that prioritizes the frail, elderly and high - risk pateints	I	😐		HF	

			14	A functional wheelchair and stretcher are always available	V	?😐		HF	
DOMAIN 6: OPERATIONAL MANAGEMENT	1. Administration	4. Management of patient record: Monitor whether patients' record content is organised according to Integrated Clinical Services Management (ICSM) prescripts, whether the prescribed stationary is used and whether the patient records are filed appropriately								
			15	There is a single patient record irrespective of health conditions	I	😐🕮		HF	
			16	Patient record content adheres to ICSM prescripts	E	😐🕮		HF	
			17	There is a single location for storage of all patient records	I	😐		HF	
			18	Patient records are filed in close proximity to patient registration desk	I	?😐		HF	
			19	There is a standardised patient record filing system in place	I	😐		HF	
			20	The retrieval of a patient 's file takes less than five minutes	I	?😐		HF	
			21	There is an SOP for archiving and disposal of patient' records available	I	🕮		NDoH	
			22	The SOP for archiving and disposal of patient' records is adhered to	I	😐		HF	
			23	Priority stationery (clinical and administrative) is available at the facility in the right quantities	I	🕮		HF	
DOMAIN 2: PATIENT SAFETY AND CLINICAL GOVERNANCE AND CLINICAL CARE	2. Integrated Clinical Services Management (ICSM)	5. Clinical Service provision: Monitor whether clinical integration of clinical care services allowing for 3 discrete streams (acute, chronic and MCWH) of service delivery is adhered to as per service package and whether this results in improvements in key population health and service indicators								
			24	The facility has been reorganised with designated consulting areas and staffing for acute, all chronic health conditions and preventative health services.	E	😐		HF	
			25	There is an area for monitoring vital signs for the different streams of care	I	😐		HF	
			26	Patient' privacy is respected at all times and in all service areas	E	😐		HF	
			27	TB treatment success rate is at least 85% or has increased by at least 10% from the previous year	E	🕮		HF	
			28	TB (new pulmonary) defaulter rate < 5%	E	🕮		HF	
			29	Ante-natal visit rate before 20 weeks gestation is at least 70%	E	🕮		HF	
			30	Ante-natal patient initiated on ART rate is at least 95%	E	🕮		HF	
			31	Immunisation coverage under one year (annualised) is at least 94%	E	🕮		HF	
			32	Screening of patients for high blood pressure has increased by 10% since the previous financial year	E	🕮		HF	
			33	Screening of patients for raised blood sugar has increased by 10% since the previous financial year	E	🕮		HF	
			34	35% of patients visiting the clinic are screened for mental disorders	E	🕮		HF	
CLINICAL Services			35	35% of patients visiting the clinic are treated for mental disorders.	E	🕮		HF	

CLINICAL GOV Services Mgt	6. Management of patient appointments: Monitor whether an ICSM pasient appointment system is adhered to.						
	36	An ICSM compliant patient appointment system for patients with stablised chronic health conditions and MCWH patient is in use	E	🕮		HF	
	37	The records of booked patients are pre retrieved 72 hours before the appointment	E	😐		HF	
	38	Patients who did not honour their appointments within one week are followed up by referral to WBPHCOT to facilitate booking of new appointment	E	? 🕮		HF	
	39	Pre-dispensed medication for clinically stable chronic patients is prepared for collection 48 hours prior to collection date.	E	? 😐		HF	
	7. Coordination of PHC Services: Monitor whether there is coordinated planning and execution between PHC facility, School Health Team, WBPHCOT and DCST						
	40	There is cooperation with School health teams in providing health services to learners	I	🕮		D	
	41	The facility refers patients with chronic but stable health conditions to WBPHCOT for support.	E	🕮		HF	
	42	There is evidence of two-way referral of patients between the PHC facility and WBPHCOT using prescribed stationary	E	🕮		HF	
	43	Quarterly clinical improvement report from DCST available	E	🕮		D	
	8. Clinical guidelines and protocols: Monitor whether clinical guidelines and protocols are available, whether staff have received training on their use and whether they are being appropriately applied.						
	44	The ICSM compliant package of clinical guidelines is available in all consulting rooms	E	🕮		D	
	45	All professional nurses and doctors have been fully trained on ICSM compliant package of clinical guidelines	E	🕮		D	
	46	All health care professionals have been trained on the management of medical emergencies	V	🕮		D	
	47	The National Adverse Event Management Protocol is available	E	🕮		NDoH	
	48	The facility's Adverse Event Management Standard Operating Procedure is available	E	🕮		HF	
	49	The Adverse Event Management records show compliance to the adverse event management protocol	E	🕮		HF	
	50	The National Clinical Audit guideline is available	E	🕮		NDoH	
	51	Clinical audit meetings are conducted quarterly in line with the guidelines	E	🕮		D	
	9. Infection Prevention and Control: Monitor whether prescribed infection prevention and control policies and procedures are adhered to.						
	52	The National Policy on Infection Prevention and Control (IPC) is available	E	🕮		NDoH	
	53	There is a staff member who is assigned infection prevention and control role in a facility	E	🕮		HF	

SAFETY AND CLINICAL GOVERNANCE AND 2. Integrated Clinical Services Management (ICSM)			54	Staff wear appropriate protective clothing	E	?😐		HF	
			55	The linen is clearly branded	I	😐		D	
			56	The linen in use is clean	E	😐		HF	
			57	The linen is appropriately used for its intended purpose	E	😐?		HF	
			58	Waste is properly segregated	E	😐		HF	
			59	Sharps containers are disposed of when they reach 2/3 capacity	V	😐		HF	
			60	Sharps are disposed in impenetrable, tamperproof containers	V	😐		HF	
			61	Sharps containers are placed on work surface only	E	😐		HF	
		10. Patient waiting time: Monitor whether the facility's prescribed waiting times are adhered to.							
			62	The National policy for the management of waiting times is available	I	😐		NDoH	
			63	The standard waiting time for every service area is visibly posted at all service areas	I	😐		HF	
			64	Waiting time is consistently monitored using the prescribed tool	E	🕮		HF	
			65	The average time patients spend in the facility is not longer than 3 hours	E	🕮		HF	
			66	Patients are intermittently informed of delays and reasons for delays in service provision	I	?		HF	
		11 Patient experience of care: Monitor whether an annual patient experience of care survey is conducted and whether patients are provided with an opportunity to complain about or compliment the facility and whether complaints are managed within the prescribed time.							
			67	The National Patient Experience of Care guideline is available	E	🕮		NDoH	
			68	The results of the yearly Patient Experience of Care survey are visibly displayed on notice board in all service areas	E	🕮		HF	
			69	The overall score obtained indicates that the patients are satisfied with the service provided	E	🕮		HF	
			70	The results obtained from the Patient experience of care survey are used to improve the quality of service provision	E	🕮		HF	
			71	The National Complaint Management Protocol is available	E	🕮		NDoH	
			72	The facility's Complaint Management Standard Operating Procedure is available	E	🕮		HF	
			73	Compliments/complaints boxes are visibly placed at main entrance/exit	E	😐		HF	
			74	There is official complaint forms and pen placed near the compliments/complaint boxes	E	😐		HF	
			75	A standardised poster appears above the complaint/compliments box inviting patients to complain to or compliment the facility about their services	E	😐		HF	

			76	The complaint records show compliance to the Complaint Management Protocol	E	🕮		HF	
			77	The monthly statistics demonstrate that complaints are resolved within 25 working days	E	🕮		HF	
			78	The monthly statistics demonstrate that all complaints are resolved	E	🕮		HF	
DOMAIN 3: CLINICAL SUPPORT SERVICES	3. Pharmaceuticals and Laboratory Services	12 Medicines and supplies: Monitor consistent availability of required good quality medicines and supplies.								
			79	There is at least one functional wall mounted minimum/maximum room thermometer in all rooms where medication is kept	V	😐		HF	
			80	The temperature of the rooms where medication is kept is recorded twice daily	V	🕮		HF	
			81	The temperature of the medicine storage room is maintained within the safety range	V	🕮		HF	
			82	There is a contingency plan to manage inappropriate room temperatures	I	🕮		HF	
			83	The temperature of the medicine refrigerator is recorded twice daily	V	🕮		HF	
			84	The temperature of the medicine refrigerator is maintained within the safety range	V	🕮		HF	
			85	There is access to an automated supply chain system for medicines	E	😐		HF	
			86	All medicines on the Essential Medicine List are consistently available	V	🕮		HF	
			87	The facility has sufficient stock to dispense chronic medication for 2 months	E	😐🕮		HF	
			88	Re-ordering stock levels (min/max) is determined for each item on the Essential Medicine List	E	😐🕮		HF	
			89	Medicines that expire within three months are returned to the depot	E	😐		HF	
			90	A list of required basic surgical supplies (consumables) indicating the re-ordering stock levels (min/max) is available	E	🕮		HF	
DOMAIN 3: CLINICAL SUPPORT SERVICES	3. Pharmaceuticals and Laboratory Services	13. Management of Laboratory Services: Monitor consistent availability and use of laboratory services.								
			91	The PHC Laboratory Handbook is available	E	🕮		NDoH	
			92	Required functional diagnostic equipment and concurrent consumables are consistently available	V	?🕮		HF	
			93	Specimens are handled according to the PHC Laboratory Handbook	E	😐		HF	
			94	The PHC laboratory results are received from the lab within the specified turn around times	E	🕮		HF	
			95	Laboratory results are filed in the patient's record within 24 hours after receiving them from the lab	E	🕮		HF	
OPERATIONAL	Human Resources for	14. Staff allocation and use: Monitor whether the PHC facility has the required HRH capacity and whether staff are appropriately applied.								
			96	Staffing needs have been determined in line with WISN	I	?🕮		D	

DOMAIN 6: OPERATIONAL MANAGEMENT	**4. Human Resources for Health**		97	Staffing is in line with WISN	I	🕮		D	
			98	A dedicated facility manager must be appointed for a facility with a workload of more than 150 patients per day and who will perform at least 80% of management work per week	E	🕮		D	
			99	Daily work allocation documentation is signed by all staff members.	I	🕮		HF	
			100	Leave policy is available	I	🕮		HF	
			101	An annual leave schedule is available	I	🕮		HF	
			102	Basic Staff records are available (vacation/sick/accouchement/ family responsibility leave/study leave/disciplinary action)	I	🕮		HF	
		15. Professional standards and Performance Management Development System (PMDS): Monitor whether staff are managed according to Department of Public Service Administration (DPSA) prescripts.							
			103	There is an individual Performance Management Agreement for each staff member	I	🕮		HF	
			104	Continued staff development needs have been determined for the current financial year and submitted to the district manager	I	🕮		HF	
			105	Training records reflect planned training is conducted as per the district training programme	I	🕮		HF	
			106	The disciplinary procedure is available	I	🕮		HF	
			107	The grievance procedure is available	I	🕮		HF	
			108	Staff satisfaction survey is conducted annually	I	🕮		D	
			109	The results of the staff satisfaction survey is used to improve the work environment	I	🕮		HF	
		16. Access to Medical, Mental health, and Allied health practitioners: Monitor patient access to clinical expertise at PHC level.							
			110	Patients have access to a medical practitioner	E	🕮		HF	
			111	Patients have access to oral health services	I	?🕮		D	
			112	Patients have access to occupational therapy services	I	?🕮		D	
			113	Patients have access to physiotherapy services	I	?🕮		D	
			114	Patients have access to dietetic services	I	?🕮		D	
			115	Patients have access to social work services	I	?🕮		D	
			116	Patients have access to radiography services	I	?🕮		D	
			117	Patients have access to ophthalmic service	I	?🕮		D	
			118	Patients have access to mental health services	E	?🕮		D	

			119	Patients have access to speech and hearing services	I	?📖		D	
DOMAIN 6: OPERATIONAL MANAGEMENT	5. Support Services	17. Finance and supply chain management: Monitor the consistent availability of a functional supply chain management system as well as the availability of funds required for optimal service provision.							
			120	The facility manager has appropriate financial delegation	I	?📖		D	
			121	The facility manager is involved in determining the budget of the facility	I	?📖		HF	
			122	The budget and actual expenditure of the facility is available	I	📖		HF	
			123	The facility has access to an automated supply chain system for general supplies	E	?📖		HF	
			124	Facility manager uses the supply chain system to ensure adequate replenishment of supplies	E	?📖		HF	
			125	Delivery of supplies are consistent with terms and conditions of the relevant contract (including set turn-around times)	E	?📖		D	
DOMAIN 7: FACILITIES AND INFRASTRUCTURE	5. Support Services	18. Hygiene and Cleanliness: Monitor whether the required systems and procedures are in place to ensure consistent cleanliness in and around a facility.							
			126	There are sufficient cleaners	E	📖		HF	
			127	All cleaners have been trained on cleaning	E	📖		HF	
			128	All work completed is signed off by cleaners	E	📖		HF	
			129	Cleaning materials are available	E	?📖		HF	
			130	Intensive cleaning of a facility is conducted during the least busy times	E	😐		HF	
			131	All service areas are clean	E	😐		HF	
			132	Clean running water, toilet paper, liquid hand wash soap and disposable hand paper towels are available	E	?📖		HF	
			133	Sanitary disposal bins with functional lids are available	E	?😐		HF	
			134	General waste bins are lined with appropriate coloured plastic bags and have functional lids in all hand washing areas and consulting rooms	E	😐		HF	
			135	All toilets are always intact and functional	E	?😐		HF	
			136	The exterior of the facility is clean	E	😐		HF	
			137	Vegetation is well trimmed	I	😐		HF	
			138	Waste is stored in access-controlled rooms	E	😐		HF	
			139	A signed waste removal service level agreement between the health department and the service provider is available	E	📖		P	
			140	Waste is removed, regularly in line with the service level agreement	E	?📖		HF	

DOMAIN 7: FACILITIES AND INFRASTRUCTURE	5. Support Services	19. Security : Monitor whether systems processes, procedures are in place to protect the safety of assets, infrastructure, patients and staff of the PHC facility.							
			141	Perimeter fencing is intact and complies with South African Police Service standards	I	😐		HF	
			142	Separate lockable pedestrian and vehicle gates are available	I	😐		HF	
			143	Adequate security lighting of the perimeter is available	I	😐👎		HF	
			144	There is a standardised security guard room	I	😐		D	
			145	A signed copy of the service level agreement between the security company and the provincial department of health is available and understood by PHC facility management and staff	I	?📖		D	
			146	Functional security equipment is available in security guard room as per service level agreement	I	😐👎		HF	
			147	Prohibited items appropriately controlled and accounted for before access is granted	I	😐📖		HF	
		20. Disaster preparedness: Monitor whether firefighting equipment is available and whether staff know how to use it and whether disaster drills are conducted.							
			148	Functional firefighting equipment is available and accessible	E	😐👎		HF	
			149	Emergency evacuation procedure practiced annually	E	📖		HF	
			150	Deficiencies identified during the practice of the emergency evacuation are addressed	E	📖		HF	
			151	Intersectoral outbreak/disaster management plan is available	I	📖		HF	
			152	Annual review and staff awareness of the intersectoral outbreak/disaster management plan	I	📖		HF	
	6. Infrastructure	21. Physical Space and Routine Maintenance: Monitor whether the physical space is adequate for the PHC facility workload and whether timely routine maintenance is undertaken.							
			153	Clinic space accommodates all services/disciplines and staff	E	😐📖		HF	
			154	The clinic has access to a functional District infrastructure maintenance hub	I	?		D	
			155	Minor repairs are promptly carried out	I	😐📖		D	
			156	Routine maintenance of the infrastructure is conducted	I	😐📖		D	
CLINICAL SUPPORT		22. Essential Equipment and Furniture: Monitor whether essential equipment and required furniture are available.							
			157	Consulting room furniture is available in every consulting room	I	😐		HF	
			158	Essential equipment is available and functional in every consulting room	E	😐		HF	
			159	Resuscitation room is equipped with functional basic equipment for resuscitation	V	😐📖		HF	
			160	Emergency trolley is cleaned and filled up at least daily and after being used	V	😐📖		HF	

DOMAIN 7: FACILITIES AND INFRASTRUCTURE			161	There is sterile emergency delivery pack.	V	😐		HF	
			162	Equipment for minor surgery is available	E	😐		HF	
			163	Oxygen supply is available	V	😐		HF	
			164	There is a protocol on resuscitation in a health facility.	E	🕮		HF	
			165	PHC facility staff are familiar with resuscitation and emergency procedures	E	?🕮		HF	
	6. Infrastructure		166	Redundant and non-functional equipment is promptly removed from the facility	I	😐		HF	
		23. Bulk supplies: Monitor whether the required electricity supply, water supply and sewerage services are constantly available.							
			167	There is consistent supply of clean, running water to the facility	V	?👎		HF	
			168	There is emergency water supply in the facility	E	?👎		HF	
			169	Water is quarterly checked for quality	I	?🕮		HF	
			170	There is functional back-up electrical supply	V	?👎		HF	
			171	The back-up electrical power supply is weekly checked to determine its functionality	V	🕮		HF	
	6. Infrastructure		172	The sewerage system is functional	E	🕮		HF	
		24. ICT Infrastructure and Hardware: Monitor whether systems for internal and external electronic communication are available and functioning.							
			173	There is a functional telephone system in the facility	E	?👎		HF	
			174	A functional public address system is available	I	?👎		HF	
			175	There is functional computer	I	?👎		HF	
			176	There is functional printer connected to the computer	I	?👎		HF	
			177	There is web access	I	?👎		D	
DOMAIN 4: PUBLIC HEALTH	7. Health Information Management	25. District Health Information System (DHIS): Monitor whether there is an appropriate information system that produces information for service planning and decision making.							
			178	Facility performance in response to burden of disease of the catchment population, is displayed and is known to all clinical staff members.	I	?😐		HF	
			179	Current disease trends inform prioritization of health care plans	I	🕮		HF	
			180	District Health Information Management System policy available	I	🕮		HF	

			181	Relevant DHIS registers are available and are kept up to date	I	?😐		HF	
			182	There is a functional computerized patient information system	I	?👎		D	
DOMAIN 6: OPERATIONAL MANAGEMENT AND	8. Communication	26. Internal communication: Monitor whether the communications system required for improved quality for service delivery is in place.							
			183	There are district quarterly facility performance review meetings	I	🕮		D	
			184	There is at least a monthly staff meeting within the facility	I	🕮		HF	
			185	Staff members demonstrate that incoming policies and notices have been read and are understood by appending their signatures on such policies and notifications	I	🕮		HF	
DOMAIN 4: PUBLIC HEALTH		27. Community engagement: Monitor whether the community participates in PHC facility activities through representation in a functional clinic committee.							
			186	There is a functional clinic committee	I	🕮		P	
			187	Contact details of clinic committee members are visibly displayed	I	😐		HF	
			188	There is an annual open days facilitated by the clinic committee	I	🕮		HF	
DOMAIN 5: LEADERSHIP AND CORPORATE GOVERNANCE	9. District Health System Support	28. District Health Support (DHS): Monitor the support provided to the facility through guidance from district management, regular Ideal Clinic status measurement by the PPTICRM as well as through visits from the district support and health programme managers.							
			189	There is a health facility operational plan in line with district health plan	I	🕮		HF	
			190	The Permanent Perfect Team for Ideal Clinic Realisation and Maintenance visits the clinic at least twice a year to record the Ideal Clinic Realization status and to correct weaknesses	E	?🕮		D	
		29. Emergency patient transport: Monitor the availability of planned and emergency transport for patients.							
			191	There is a pre-determined ambulance response time to the facility	I	?🕮		D	
			192	Ambulances respond in line with the pre-determined response time	I	🕮		D	
		30. Referral System: Monitor whether patietns have access to appropriate levels of health care.							
			193	The National Referral Policy is available	I	🕮		NDoH	
			194	The facility's Standard Operating Procedure for referrals is available and sets out clear referral pathways	I	🕮		HF	
			195	There is a referral register that records referred patientss	I	🕮		HF	
			196	Referral records indicate feedback from destination facilities	I	🕮		HF	

			197	There is a standard National Referral form that is used by all for referring pateints	I	🕮		NDoH	
DOMAIN 5: LEADERSHIP AND CORPORATE GOVERNANCE	10. Partners and Stakeholders	31. Implementing Partners support: Monitor the support that is provided by implementing partners							
			198	There is an up to date list (*with contact details*) of all implementing partners that support the facility	I	🕮		HF	
			199	The list of implementing health partners shows their areas of focus and business activities	I	?🕮		HF	
			200	Implementing health partners perform in relation to their focus area and business activities	I	?🕮		HF	
		32. Multi-sectoral collaboration: Monitor the systems in place to respond to the social determinants of health							
			201	There is an official Memorandum of Understanding between the PDOH and SAPS	I	🕮		P	
			202	There is an official Memorandum of Understanding between the PDOH Department of Education	I	🕮		P	
			203	There is an official Memorandum of Understanding between the PDOH and the Department of Social Development	I	🕮		P	
			204	There is an official Memorandum of Understanding between the NDOH and Department of Home Affairs	I	🕮		NDoH	
			205	There is an official Memorandum of Understanding between the PDOH and Department of Public Works	I	🕮		P	
			206	There is an official Memorandum of Understanding between the district management and Cooperative Governance and Traditional Affairs (CoGTA)	I	🕮		D	
			207	There is an official Memorandum of Understanding between the PDOH and department of transport	I	🕮		P	

ANNEXURE 3- Works Order

DEPT. SECTION …… INSTITUTION ……..

KINDLY EXECUTE THE FOLLOWING SERVICE:

A SEPARATE FORM MUST BE COMPLETED FOR EACH SERVICE

_____
_____
_____
_____
_____
_____

SIGNATURE …….. RANK …… DATE……..

ARTISAN …….. HEAD OF SECTION ……..

WORKSHOP …….. REMARKS ……..

ORDER NO …….. ……..

FOREMAN …….. WORK COMPLETED BY ……

DATE …….. COMPLETED WORK

HANDED OVER TO ……..

SIGNATURE …….. DATE ……..

ANNEXURE 4- Facility Internal Signage: Checklist

Scoring: In column for Score mark as follow: present = 1; not present =0 ; not applicable = NA

Signage	Score
Helpdesk and/or Reception	
Accident/ Emergency room	
Consultation rooms for Acute and Minor ailments	
Consultation rooms for Chronic disease management	
Consultation rooms for Maternal Child Health and Women's health	
Consultation room (for facilities that are small and therefor do not have enough staff to implement the 3 streams of care)	
Vital rooms for Acute and Minor ailments	
Vital rooms for Maternal Child Health and Women's health	
Vitals rooms for Chronic disease management	
Vitals room (for facilities that are small and therefor do not have enough staff to implement the 3 streams of care)	
Pharmacy or Medicine store room	
Counseling Room	
Manager's Office	
Medical Records room	
Nurses Station	
Staff Change Rooms & Lockers	
Staff Rest rooms	
Toilets: Male Female Disabled	
Exits	
Emergency Exits	
If fire-fighting equipment is not positioned prominently, the position of the equipment must be indicated by symbolic safety signs.	
CHCs	
Maternity Unit and/or Labour ward	
Wards and Specialty Clinics	
Total Score	
Maximum possible score (sum of all scores (24) minus the ones marked NA)	
Percentage (Total score/maximum possible sore)*100	**%**

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

ANNEXURE 5- Staff Dress Code and Insignia

Dress code for Nursing Staff

Wear the prescribed uniform for females, as follows:

- White blouses, but never the see- through type
- Navy jersey/jacket in the winter season (to be removed when entering the department/hospital)
- Navy skirt/slacks
- Navy/black court/flat shoes - no clogs, Crocs, sandals or slip-ons allowed
- Skin colour stockings to be worn
- Only one pair of stud earrings to be worn
- Epilates according to the nursing staffs qualification

Wear the prescribed uniform for males, as follows:

- White shirts
- Navy jersey/jacket in the winter season (to be removed when entering the department/hospital)
- Navy trousers
- Navy blue/black socks
- Black shoes – no clogs, Crocs, sandals or slip-ons allowed
- Only one pair of stud earrings to be worn
- Epilates according to the nursing staffs qualification

Dress code for Administration staff, Data capturers:

- White shirts
- Navy jersey/jacket in the winter season (to be removed when entering the department/hospital)
- Navy trousers
- Navy blue/black socks
- Black shoes – no clogs, Crocs, sandals or slip-ons allowed
- Only one pair of stud earrings to be worn

Dress code for General assistants:

- White shirts
- Navy jersey/jacket in the winter season (to be removed when entering the department/hospital)
- Navy trousers
- Navy blue/black socks
- Black shoes – no clogs, Crocs, sandals or slip-ons allowed
- Only one pair of stud earrings to be worn

Dress code for Community Health Workers:

• White shirts • Navy jersey/jacket in the winter season (to be removed when entering the department/hospital) • Navy trousers • Navy blue/black socks • Black shoes – no clogs, Crocs, sandals or slip-ons allowed • Only one pair of stud earrings to be worn
An ID tag shall include the following information: • emblem of the provincial Department of Health • full names and surname of the staff member • Staff designation eg: "professional nurse", “data capturer”, “general assistant • Recent photo of registered practitioner, to be replaced every 10 years

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

Scoring: In column for Score mark as follow: dressed according to dress code = 1; not dressed according to dress code = 0; if the facility has less than 10 staff members = NA

Staff member	Score
Staff member 1	
Staff member 2	
Staff member 3	
Staff member 4	
Staff member 5	
Staff member 6	
Staff member 7	
Staff member 8	
Staff member 9	
Staff member 10	
Total Score	
Maximum possible score (sum of all scores (25) minus the ones marked NA)	
Percentage (Total score/maximum possible sore)*100	**%**

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

ANNEXURE 6- Staff Dress Code: Record of Training

Training Conducted: Prescribed dress code

Surname	Name	Persal number	Designation	Date trained	Signature

ANNEXURE 7- Disability Access: Checklist

Scoring: In column for Score mark as follow: present and functional = 1; not present or not functional =0

Item	Score
All main entrances accessible to a disabled person.	
Entrance accessible to a wheelchair user.	
Entrance connected by accessible pathways to parking areas, local public transport and drop-off areas.	
Entrances clearly identified using the international symbol of accessibility.	
Railings and handrails to comply with the below requirements, or be modified or replaced.	
Safety guards or railings installed around hazardous areas, stairs, ramps, accessible roofs, mezzanines, galleries, balconies and raised platforms more than 0.40 m high.	
Windows on stairways positioned less than 1.00 m from the landing have railings.	
Handrails installed in bathrooms and toilets a. Handrails do not obstruct the path of travel. b. A second handrail mounted between 0.70 m and 0.75 m from the floor for wheelchair users.	
Railings securely attached to the wall or to a supporting structure.	
Ramps with landings for resting, maneuvering and avoiding excess speed.	
A non-slip surface finish on slippery ramps.	
A textural strip at the top and bottom of the ramp for sightless people to locate the ramp.	
Adequate drainage at the end of the ramp to avoid accumulation of water.	
Total Score	**/13**
Percentage (Total score/13)*100	**%**

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

ANNEXURE 8- Triage of Chronic Patients

Triaging of chronic patients

After completing the vital signs, the patients should be further triaged into the following categories and directed appropriately:

- Repeat medication with normal vital signs
- Repeat medication with abnormal vital signs
- Six month full examination
- Doctor referral.

Designation of chronic consulting rooms

- After calculating the number of consulting rooms required to consult chronic patients, it is important to identify the most suitable consulting rooms for chronic patients.

Criteria for Chronic Consulting Room

- The ideal is to allocate consulting rooms that are adjacent to each other if more than one consulting room is to be used.
- Ensure that there is no cross flow between patients.
- The patients should be able to exit easily after consultation without having to re-enter the main clinic area.

The chronic consultation room should:

- Be well ventilated
- Have a hand washing basin in the room or adjacent to it
- Have a desk with a lock up drawer and three chairs
- Have a lock up cabinet for storage of patient medication
- Contain three colour-coded waste containers.

Equipment for Chronic Consulting Room

- Basic diagnostic set ophthalmoscope and otoscope
- Thermometer
- Stethoscope
- Urine dipsticks
- Blood glucometer
- Sphygmomanometer
- Peak flow meter
- Patella hammer
- An appropriate medical consulting bed
- A mobile examination lamp

Stationary for Chronic Consulting Room

- Clinical support tools for provider (clinical algorithms (PC101)), drug dosing guides (EDL), desktop guides, posters, textbooks, etc.)
- Patient education posters
- Other forms:
  - Laboratory requests
  - Prescription forms
  - Transfer or referral forms
  - Reporting forms
  - Continuation sheets for clinical records

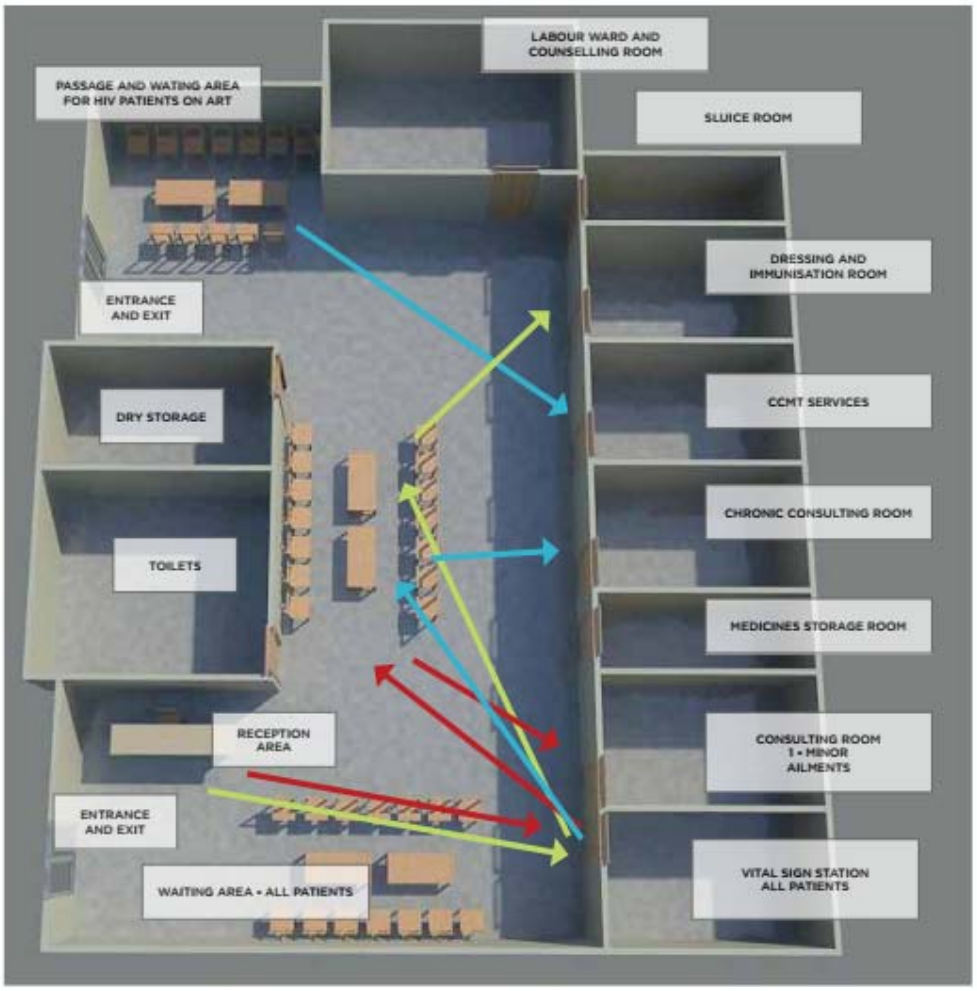


Figure 1: Typical Patient Flow in a Clinic

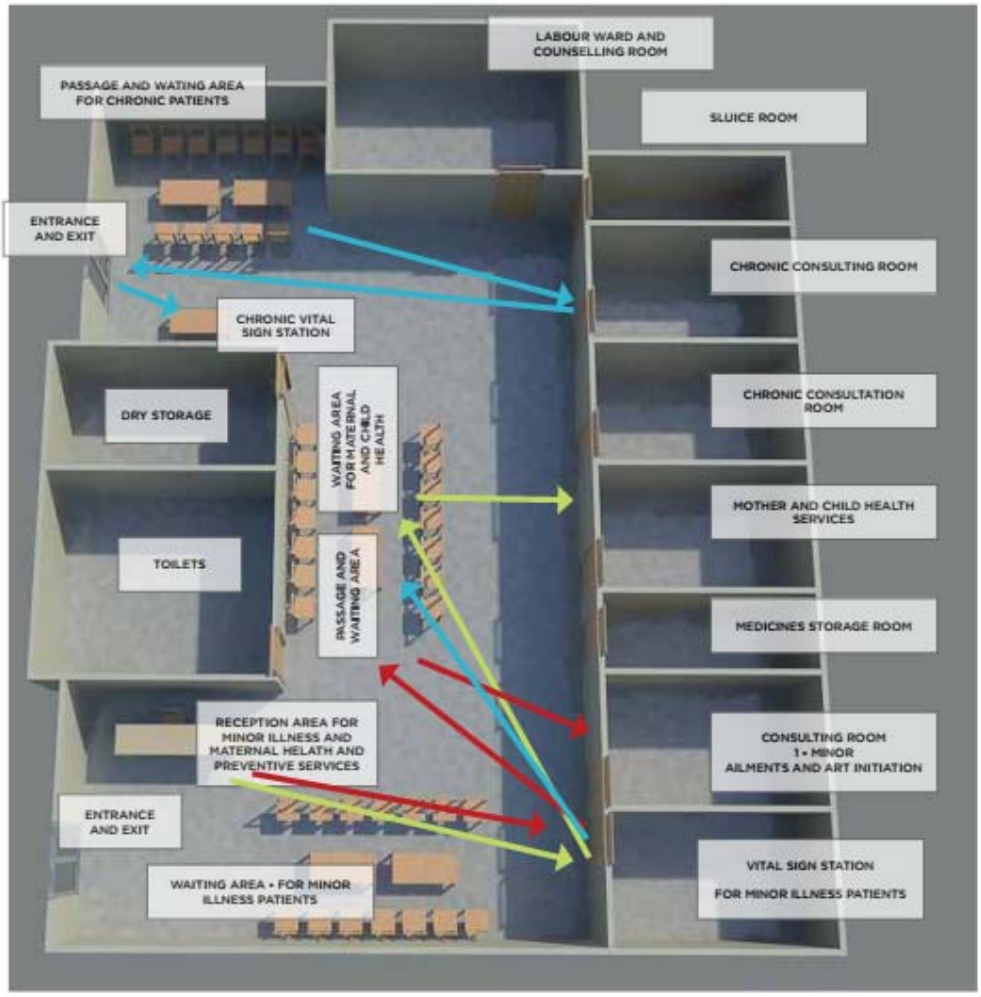


Figure 2: Example of Re-organised Patient Flow

Pre-appointment retrieval of patient records

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

ANNEXURE 9- Triage Notice

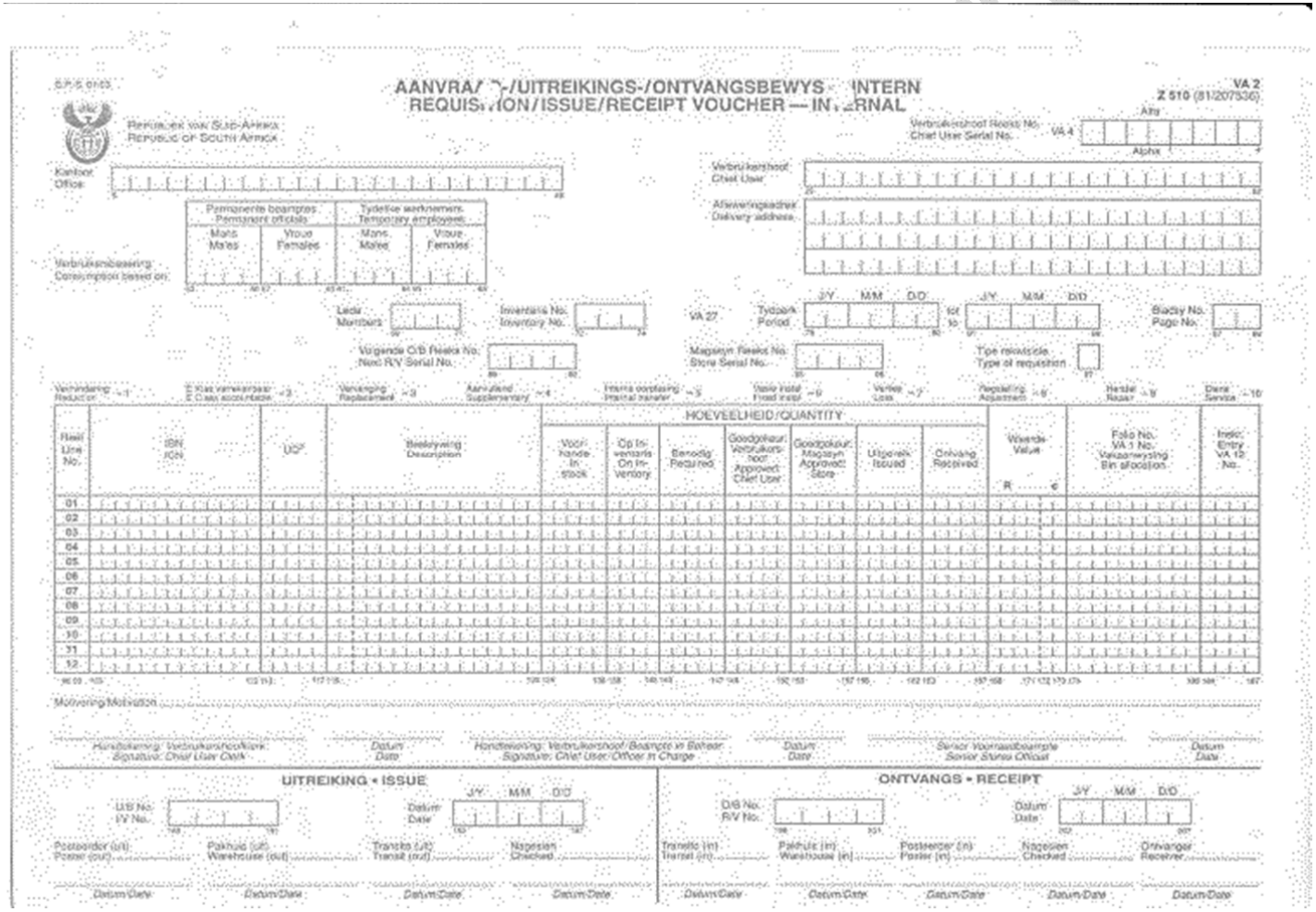
PLEASE NOTE

FRAIL, ELDERLY AND HIGH-RISK CLIENTS

WILL BE GIVEN PRIORITY

AND MOVED TO THE FRONT OF THE QUEUE

ANNEXURE 10- Standard Procurement Form



AANVRA/ ?-/UITREIKINGS-/ONTVANGSBEWYS - INTERN
REQUIS.TION/ISSUE/RECEIPT VOUCHER — IN..RNAL

VA 2
Z 510 (81/207936)

Republiek van Suid-Afrika
Republic of South Africa

Kantoor
Office

Verbruikershoof Rekstr No.
Chief User Serial No.

Verbruikershoof
Chief User

Afleweringsadres
Delivery address

Permanente beamptes
Permanent officials
Mans
Males
Vroue
Females

Tydelike werknemers
Temporary employees
Mans
Males
Vroue
Females

Verbruiksberaming
Consumption based on

Lede
Members

Inventaris No.
Inventory No.

VA 27

Tydperk
Period
J/Y M/M D/D
tot
to
J/Y M/M D/D

Bladsy No.
Page No.

Vorige O/B Rekstr No.
Next R/V Serial No.

Magasyn Rekstr No.
Store Serial No.

Tipe rekwisisie
Type of requisition

Verhindering - 1
Reduction

Klas verrekenbaar - 3
Class accountable

Vervanging - 3
Replacement

Aanvullend - 4
Supplementary

Interne oordrag - 5
Internal transfer

Vaste inslag - 6
Fixed issue

Verlies - 7
Loss

Regstelling - 8
Adjustment

Herstel - 9
Repair

Diens - 10
Service

HOEVEELHEID/QUANTITY

Reël Lyn No.	ISBN /ION	UD*	Beskrywing Description	Voorhande In stock	Op Inventaris On Inventory	Benodig Required	Goedgekeur: Verbruikershoof Approved: Chief User	Goedgekeur: Magasyn Approved: Store	Uitgereik Issued	Ontvang Received	Waarde Value R c	Folio No. VA 1 No. Vakaanwysing Bin allocation	Insk: Entry VA 12 No.
01													
02													
03													
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06													
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09													
10													
11													
12													

Motivering/Motivation

Handtekening: Verbruikershoof/Offisier
Signature: Chief User/Officer

Datum
Date

Handtekening: Verbruikershoof/Beamptes in Beheer
Signature: Chief User/Officer in Charge

Datum
Date

Senior Voorraadbeampte
Senior Stores Official

Datum
Date

UITREIKING • ISSUE

U/S No.
R/V No.

Datum
Date
J/Y M/M D/D

Posbesorger (uit)
Poster (out)

Pakhuis (uit)
Warehouse (out)

Transito (uit)
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Nagesien
Checked

Datum/Date | Datum/Date | Datum/Date | Datum/Date

ONTVANGS • RECEIPT

O/B No.
R/V No.

Datum
Date
J/Y M/M D/D

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Transit (in)

Pakhuis (in)
Warehouse (in)

Posbesorger (in)
Poster (in)

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Checked

Ontvanger
Receiver

Datum/Date | Datum/Date | Datum/Date | Datum/Date | Datum/Date

ANNEXURE 11- Filing Protocol: File Numbers

Correct filing protocol includes the following segments, concatenated to form a proper file number:

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

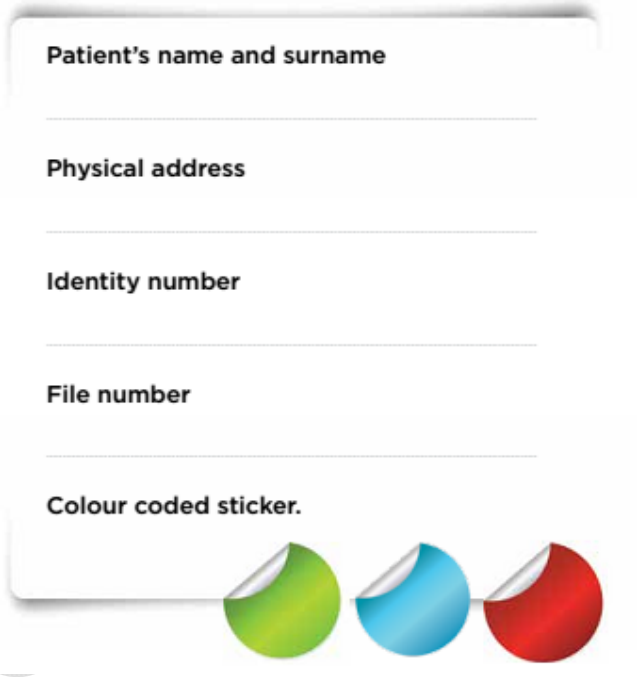
ANNEXURE 12- Client Record Filing System

Integration of clinical records

- Each patient (except active TB patients) should have a single file for acute and chronic records.
- The facility should have a single system for filing and storing all patients' clinical records.
- The records should not be stored per diagnostic condition but rather by the first three letters of the patient surname and date of birth, or address e.g. ASM600108 or as per provincial/district filing protocol.
- In order to identify a chronic patient's record a colour coded sticker (blue) should be affix to the front cover.

Organisation of the chronic record

- The front cover of the clinical record should display the following:



ANNEXURE 13- Stationary Catalogue

Clinical and Administrative Stationary Catalogue

Scoring: In column for Score mark as follow: present = 1; not present =0 ; Not applicable =NA

Stationary Type	Facilities' minimum quantity	Score
TPH25		
Brown Client Folder		
Antenatal Cards		
TB Folder		
EPI record		
Road to Health Booklet Boys Girls		
Chronic Records • Non communicable o Diabetes o Asthma o Hypertension o Epilepsy o Mental Health • Communicable o TB form TPH** o HIV		
Appointment Cards • TB • General • Pre-ART • ART		
Registers		
Tick Sheets		

WBPHCOT forms		
Patient record identification sheet		
ART record		
Reporting Form		
ANC Register		
Wellness Register		
Total Score		
Maximum possible score (sum of all scores (25) minus the ones marked NA)		
Percentage (Total score/maximum possible sore)*100		**%**

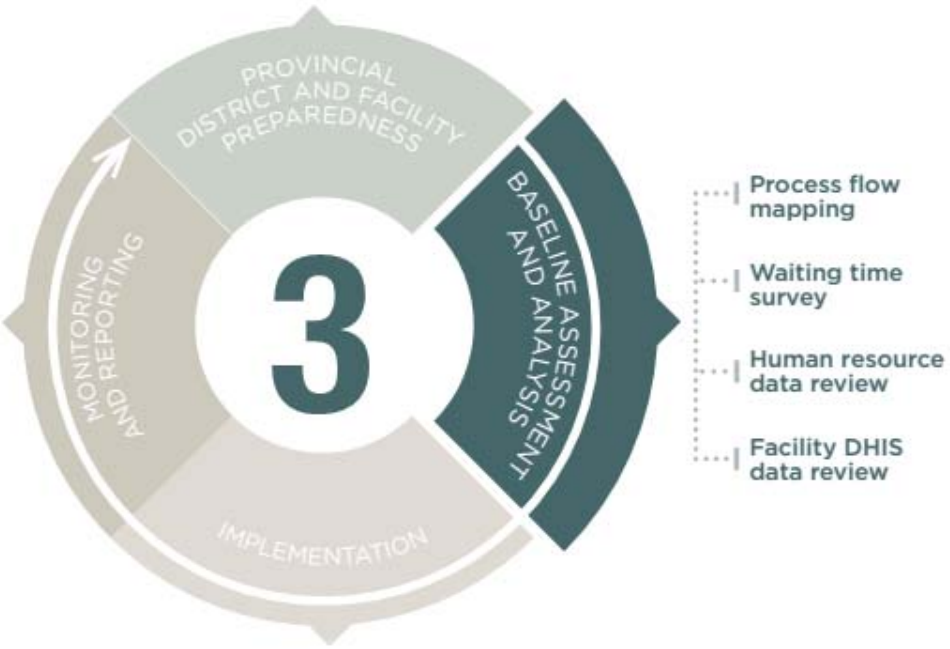
Percentage obtained	**Score**
100%	Green
40-99%	Amber
<40%	Red

ANNEXURE 14- Process Flow Mapping

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

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

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



1. Theoretical framework

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

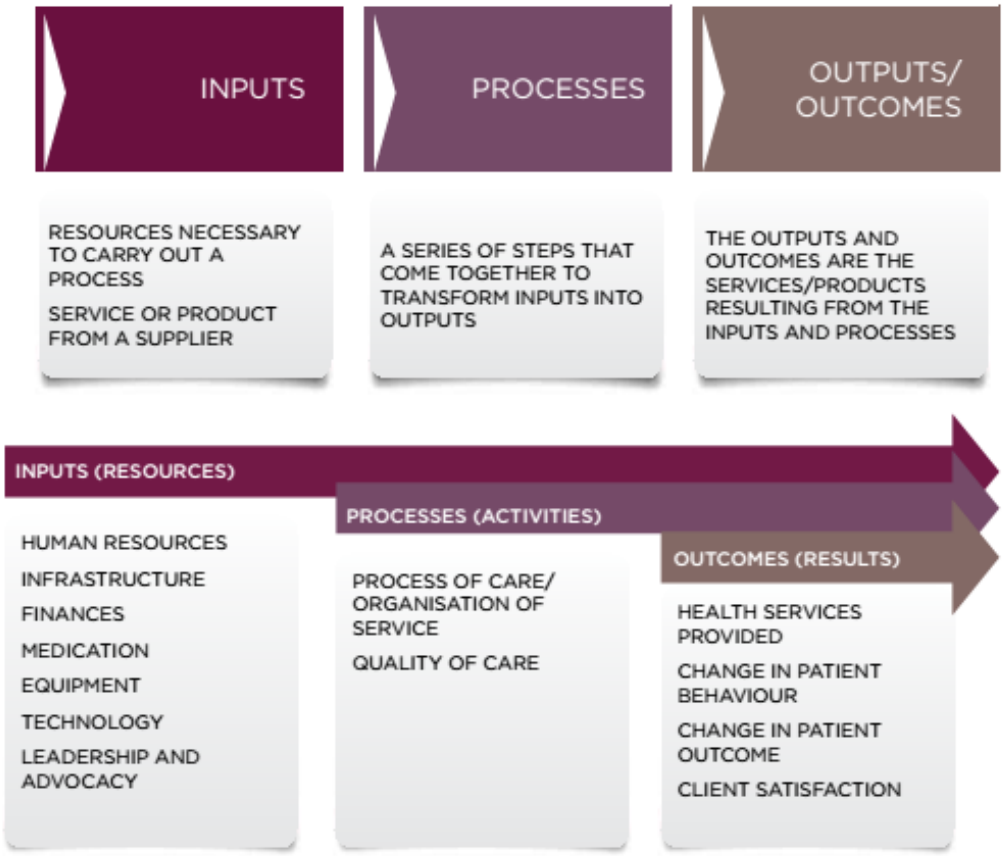


Figure 1: Modified Systems Framework for Health Service Delivery

2. The baseline assessment for ICDM involves:
    - Conducting a waiting time survey or review of previous waiting time survey to determine the baseline for future comparisons
    - Patient flow analysis - this will be used to identify areas of bottleneck within the healthcare process
    - Reviewing the last quarter facility health information to determine the number of chronic patients to schedule for daily to achieve an even distribution of patients
    - Reviewing of human resource data in order to plan the training programme based on the service requirements.

Figure 2: Activity Steps for Baseline Assessment

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

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

The waiting time survey consists of two sections:

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

FACILITY SPECIFIC: DATA SUMMARY SHEET

ON THE DAY OF THE SURVEY:

1. The operational manager will complete the facility-specific data summary sheet by indicating the date(s) that the survey was conducted.
2. On the morning of the survey, use the information from the staff attendance register to fil in how many professional nurses are on duty. This is only for primary healthcare and not labour/delivery services (MOU), but must include the nurses doing antenatal care.
3. Indicate the number of enrolled nurses/enrolled nursing assistants on duty.
4. Indicate the number of clerks on duty for the day.

TOOL 16

Facility-specific data summary sheet for waiting time survey

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

Waiting time survey methodology

1. All facilities involved in the ICDM project within the district should conduct the survey during the same week with the same start date.
2. A total of 100 patients should be sampled per facility.

FACILITY SPECIFIC: THE SURVEY

THE SURVEY

1. The 1st 100 patients attending the facility, irrespective of diagnosis, should be surveyed using the waiting time survey tool.
2. ROW 1 the queue marshal/enrolled nurse should enter the time that each patient enters the clinic.
3. ROW 2 the administrative clerk registering the patient should complete the time after he/she completes the patient registration.
4. ROW 3 the enrolled nurse/enrolled nursing assistant at the vital sign station should complete the time after the vital signs have been completed.
5. ROW 4 the professional nurse should indicate at what time the patient entered the consulting room
6. ROW 5 the professional nurse should enter time after he/she completes the consultation.
7. The professional nurse should also complete the diagnostic information of the patient
8. ROW 6 if the patient is referred to another professional nurse or to another service point, for example to receive medication, then the service provider must fil in the time the patient enters the second consultation room.
9. ROW 7 when the patient departs the second consultation area, this will be completed.
10. ROW 8 the form should be collected by the queue marshal/ professional nurse and the time that the patient departs the facility should be indicated.

TOOL 17

Waiting time survey tool

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

FACILITY SPECIFIC: AFTER THE SURVEY

AFTER THE SURVEY

1. If all 100 patients surveyed are completed in a single day, use the register to provide the total number of outpatients seen for that day and enter this on Tool 15
2. If the 100 patients surveyed are done on sequential days, then add the total number of patients consulted over the period of days on which the survey was done and also indicate the dates.
3. The data should then be forwarded to the facility Information officer for entry into Microsoft Excel.

STEP 2: DRAW THE ACTUAL FLOOR PLAN OF THE FACILITY AN ARCHITECTURAL SKETCH

- The operational manager and the ICDM champion should sketch the layout of the actual facility
- Each area in the floor plan should be labelled and described in terms of the activity that takes place in that area.

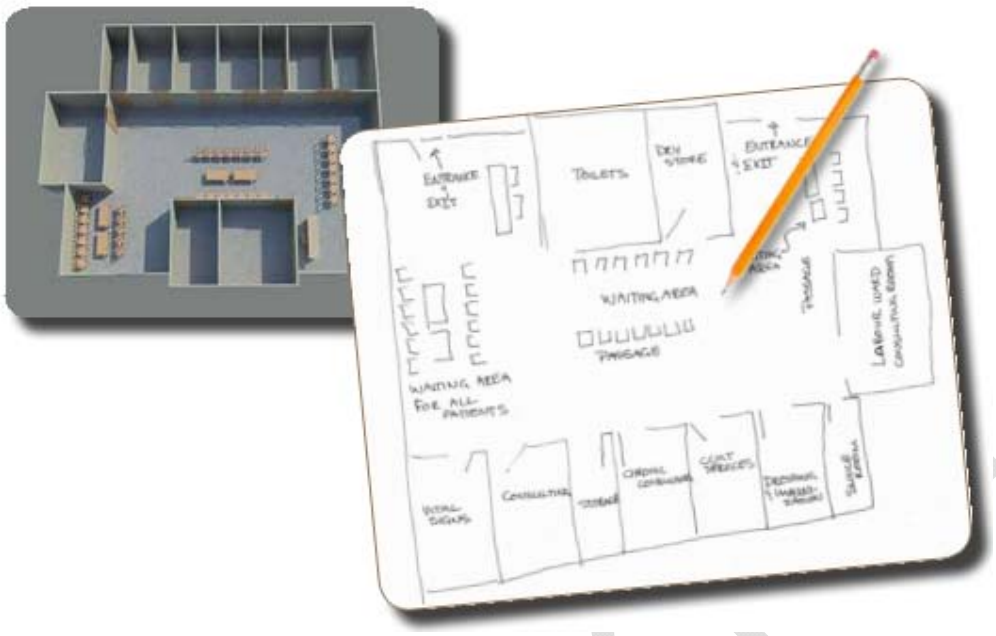


Figure 3: Example of a Sketched Floor Plan

STEP 3: CHART OUT THE PROCESS FLOW

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

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

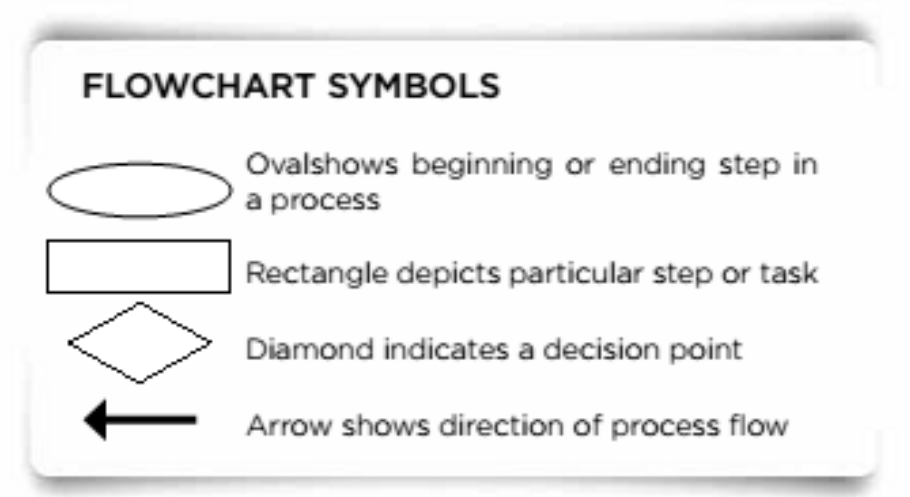


Figure 4: Flowchart Symbols to be used for Depicting Process Flow

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

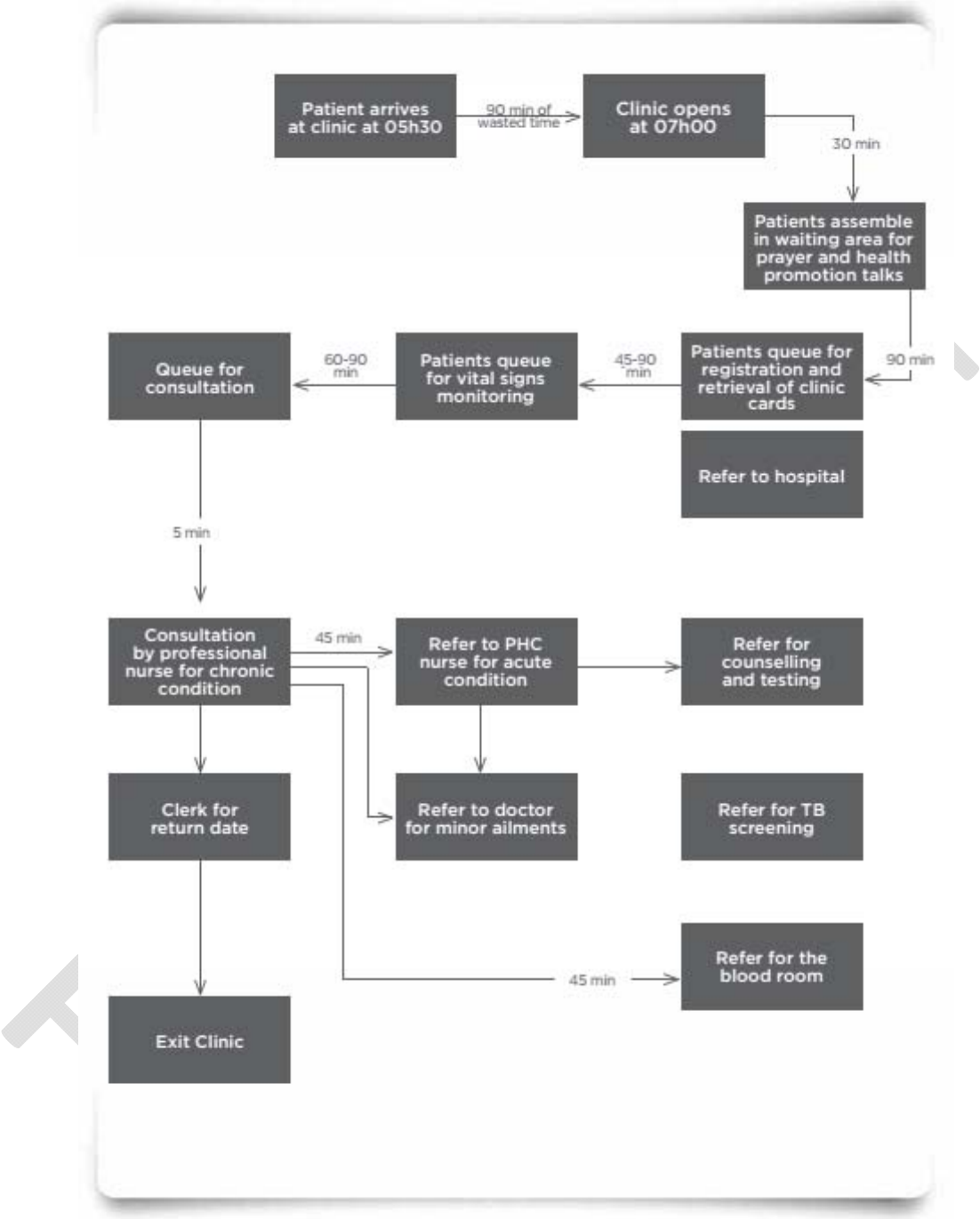


Figure 5: Example of a Process Flow Plan

STEP 4: REVIEW THE HUMAN RESOURCES DATA

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

TOOL 18

Staff development needs assessment

		TRAINING COMPLETED					
NAME OF PROFESSIONAL NURSE	South african nursing council registration number	Primary healthcare	Palsa plus	Nurse initiated art (NIMART)	Mental health	Advanced midwifery	PC 101

STEP 5: REVIEW THE FACILITY DHIS INFORMATION FOR THE LAST QUARTER

TOOL 19

Summary sheet for DHIS data for the last quarter

HEALTH INFORMATION FOR THE LAST QUARTER	QUARTER:
PHC headcount (< 5 years + > 5 years)	
PHC headcount > 5 years	
Number of HIV patients currently on ART new	
Total number of HIV patients remaining on ART	
Number of patients on pre-ART	
Number of TB patients > 8 years receiving monthly medication	
Number of TB MDR confirmed patients initiated on treatment	
Total number of chronic NCD patients new and follow up (to arrive at this total- sum up the six (6) indicators below)	
Hypertension case load - number of patients with HPT > 5 years visiting the clinic	
Diabetes case load - number of patients with diabetes > 5 years visiting the clinic	
Epilepsy case load - number of patients with epilepsy > 5 years visiting the clinic	
Asthma case load - number of patients with asthma > 5 years visiting the clinic	
Chronic obstructive airway disease (COPD) case load - number of patients with COPD > 5 years visiting the clinic	
Mental health case load - number of patients with mental health > 5 years visiting the clinic	

3. Baseline Analysis

Figure 6: baseline analysis activities

STEP 1: WAITING TIME ANALYSIS

- Assess the following information from the survey:
- Nurse to patient ratio - total number of professional nurses on duty on date of survey / total number of patients consulted at facility on the date of the survey
- Total median time spent by all patients at the facility
- Total median waiting time spent by chronic (HIV and NCD) patients
- Total median waiting time between clinic entry and registration
- Total median waiting time between registration and vital signs completion
- Total median waiting time between vital signs completion and consultation

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

STEP 2: PROCESS FLOW ANALYSIS

After completing the mapping exercise the team should sit in a meeting room and pin the map on a board.

The following question should be answered in analysing the information and for each symptom the question why should be posed to generate possible solutions.

At which point do patient wait the longest and why?

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

TOOL 20

Process flow and waiting time analysis template

SERVICE DELIVERY POINT	SYMPTOM: LONG WAITING TIME
Area A – e.g. between entry and registration	Why? Batching - all patients arriving at a single point together, e.g. all patients arrive at the clinic at 06h30 when the clinic opens at 07h00. Over-processing - patient having to go through a process that can be avoided People - availability of the correct type of human resources Equipment - availability of equipment
Between registration and vital signs	
Between vital signs and consultation	
Between consultation and additional service points	
Between consultation and departure from clinic	

STEP 3: HUMAN RESOURCE DATA ANALYSIS

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

TOOL 21

Summary of human resource data

	NUMBER
Total number of professional nurses employed at the facility	
Total number of enrolled nurses employed at the facility	
Number of professional nurses PHC trained	
Number of professional nurses PALSA Plus trained	
Number of professional nurses NIMART trained	
Number of professional nurses PC 101 trained	
STAFF DEVELOPMENT	
Number of professional nurses that require to be trained	
PHC	
NIMART	
PC 101	

STEP 4: ANALYSE THE FACILITY SPECIFIC DHIS INFORMATION

TOOL 22

Analysis of DHIS information for the facility

INDICATORS	NUMBER/%	FORMULA
Total PHC headcount		
Proportion of patients > 5 years		(PHC headcount > 5 years / total PHC headcount)
Total number of NCD patients		(hypertension case load + diabetes case load + epilepsy case load + asthma case load + chronic obstructive pulmonary disease case load + mental health case load)
HIV patients on ART case load		(number of new patients on ART + total number remaining on ART)
Pre-ART HIV patients		
TB patients > 8 years receiving monthly medication		
Number of TB MDR confirmed patients initiated on treatment		
Total chronic patient case load		(total number of NCD patients + HIV patients on ART case load + pre-ART HIV patients + TB patients > 8 years receiving monthly medication + number of MDR TB patients initiated on treatment)

THIS INFORMATION THAT YOU HAVE WILL NOW MAKE IT POSSIBLE FOR YOU TO DEVELOP THE ICDM IMPLEMENTATION PLAN.

ANNEXURE 15- Appointment Scheduling Process

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

- The scheduling of patients should be done by the professional nurse in the consulting room if a single consultation room is used for consulting chronic patients.
- If more than one consulting room is being used, a number of options could be considered:

  • Each professional nurse should be allocated a maximum number of patients that could be booked per day within the respective week and the professional nurse could transcribe them on the scheduling book

  • An administrative clerk could be stationed in a convenient area and schedule the patients according to the information provided by the professional nurse on the chronic patient record.

Determining the appointment date

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

- A monthly basis if unstable or complicated patient
- Every 2nd or 3rd month for a repeat prescription if the patient is clinically stable
- After six months if the patient has been down referred to the PHC outreach team.

Scheduling the appointment

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

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

TOOL 25

Appointment scheduling format - no time slots

DATE OF APPOINTMENT						
CALENDAR DAY						
NO	PATIENT FILE NUMBER	SURNAME AND INITIALS OF PATIENT	DIAGNOSTIC CONDITION	COMMENTS	FILE RETRIEVED (Y/N)	PATIENT ATTENDED (Y/N)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
NON-SCHEDULED PATIENTS						
1						
2						
3						
4						
5						

Date of appointment

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

No.

Number refers to the numerical order in ascending order. This will guide you as to when you reach your target appointments for the respective date, e.g. 32 per day.

Calendar day

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

Patient file number

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

Surname and initials

This should be as reflected in patient's identity documents and /or patient records.

Diagnostic condition

This refers to the chronic condition for which the patient is booked for, e.g. hypertension, diabetes, epilepsy, asthma, COPD, ART.

Comments

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

- Patient defaulted-referred for tracing - you can add address and health tracers name
- Doctor appointment
- Six month appointment
- Repeat prescription and collection of medication
- Referred to ophthalmologist/ophthalmic nurse
- Referred to social worker.

File retrieved

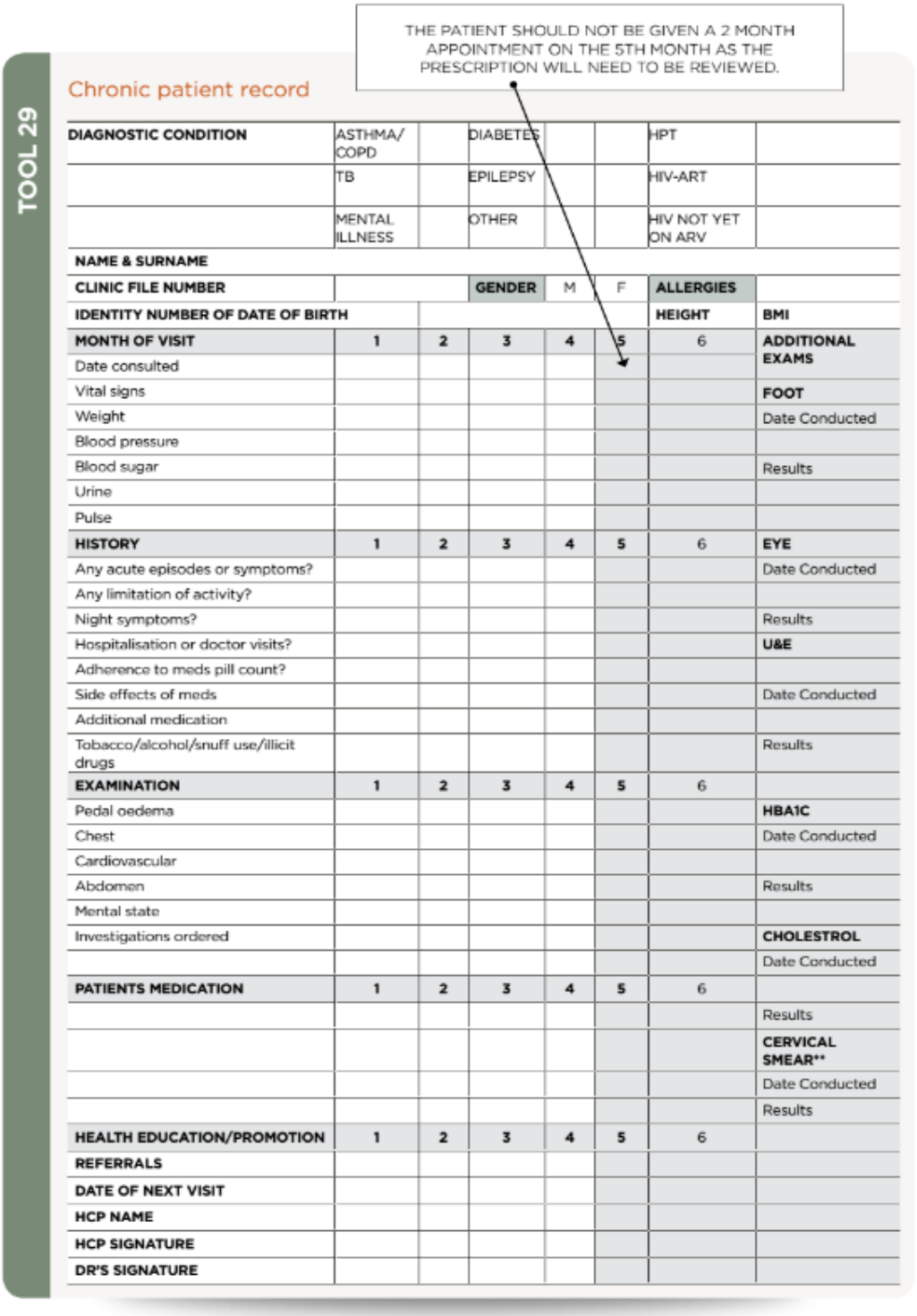
Pre-appointment retrieval of patient records needs to be done 1-3 days prior to the appointment. When the administrative clerk retrieves the patient's fie, a tick should be

made in this column to indicate the file has been retrieved. A cross should be made in red pen if the fie is not found and this should be attended to.

ANNEXURE 16- Pre-dispensing of Chronic Medication

- Two days prior to the patient's appointment, the patient's clinical records and scheduling list should be provided to the allocated professional nurse for chronic patients or the pharmacy 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.
- The bag should not be closed as to validate the medication on dispensing to the patient.
- Where plastic bags are not available the facility should adopt innovative measures to pre-dispense the medication
- 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 is to be dispensed by a pharmacist assistant.

ANNEXURE 17- Chronic Patient Medication Record



TOOL 29

THE PATIENT SHOULD NOT BE GIVEN A 2 MONTH APPOINTMENT ON THE 5TH MONTH AS THE PRESCRIPTION WILL NEED TO BE REVIEWED.

Chronic patient record

DIAGNOSTIC CONDITION	ASTHMA/ COPD		DIABETES			HPT	
	TB		EPILEPSY			HIV-ART	
	MENTAL ILLNESS		OTHER			HIV NOT YET ON ARV	
NAME & SURNAME							
CLINIC FILE NUMBER			**GENDER**	M	F	**ALLERGIES**	
IDENTITY NUMBER OF DATE OF BIRTH						**HEIGHT**	**BMI**
MONTH OF VISIT	**1**	**2**	**3**	**4**	**5**	6	**ADDITIONAL EXAMS**
Date consulted							
Vital signs							**FOOT**
Weight							Date Conducted
Blood pressure							
Blood sugar							Results
Urine							
Pulse							
HISTORY	**1**	**2**	**3**	**4**	**5**	6	**EYE**
Any acute episodes or symptoms?							Date Conducted
Any limitation of activity?							
Night symptoms?							Results
Hospitalisation or doctor visits?							**U&E**
Adherence to meds pill count?							
Side effects of meds							Date Conducted
Additional medication							
Tobacco/alcohol/snuff use/illicit drugs							Results
EXAMINATION	**1**	**2**	**3**	**4**	**5**	6	
Pedal oedema							**HBA1C**
Chest							Date Conducted
Cardiovascular							
Abdomen							Results
Mental state							
Investigations ordered							**CHOLESTROL**
							Date Conducted
PATIENTS MEDICATION	**1**	**2**	**3**	**4**	**5**	6	
							Results
							CERVICAL SMEAR**
							Date Conducted
							Results
HEALTH EDUCATION/PROMOTION	**1**	**2**	**3**	**4**	**5**	6	
REFERRALS							
DATE OF NEXT VISIT							
HCP NAME							
HCP SIGNATURE							
DR'S SIGNATURE							

TOOL 29 (CNTD)

Chronic patient record

DIAGNOSTIC CONDITION	ASTHMA/ COPD		DIABETES			HPT	
	TB		EPILEPSY			HIV-ART	
	MENTAL ILLNESS		OTHER			HIV NOT YET ON ARV	
NAME & SURNAME							
CLINIC FILE NUMBER			**GENDER**	M	F	**ALLERGIES**	
IDENTITY NUMBER OF DATE OF BIRTH						**HEIGHT**	**BMI**
MONTH OF VISIT	**7**	**8**	**9**	**10**	**11**	12	**ADDITIONAL EXAMS**
Date consulted							
Vital signs							**FOOT**
Weight							Date Conducted
Blood pressure							
Blood sugar							Results
Urine							
Pulse							
HISTORY	**7**	**8**	**9**	**10**	**11**	12	**EYE**
Any acute episodes or symptoms?							Date Conducted
Any limitation of activity?							
Night symptoms?							Results
Hospitalisation or doctor visits?							**U&E**
Adherence to meds pill count?							
Side effects of meds							Date Conducted
Additional medication							
Tobacco/alcohol/snuff use/illicit drugs							Results
EXAMINATION	**7**	**8**	**9**	**10**	**11**	12	
Pedal oedema							**HBA1C**
Chest							Date Conducted
Cardiovascular							
Abdomen							Results
Mental state							
Investigations ordered							**CHOLESTROL**
							Date Conducted
PATIENTS MEDICATION	**7**	**8**	**9**	**10**	**11**	12	
							Results
							CERVICAL SMEAR**
							Date Conducted
							Results
HEALTH EDUCATION/PROMOTION	**7**	**8**	**9**	**10**	**11**	12	
REFERRALS							
DATE OF NEXT VISIT							
HCP NAME							
HCP SIGNATURE							
DR'S SIGNATURE							

ANNEXURE 18- School Health Team Feedback Form

ANNEXURE 19- Ward-based Primary Health Care Outreach Teams

BUILDING THE CAPACITY OF PATIENTS AND COMMUNITIES

The PHC ward based outreach team (WBOT) to support and capacitate patients and communities to take responsibility for their own health and focus of the "assisted" self-management component is to utilise the well-being.

The aim of the self-management component of the ICDM model is to empower chronic patients to take responsibility to manage their illness through understanding the necessary preventive and promotive actions required to decrease complications and multiple encounters with the health system.

The expected outcome is to create an informed, motivated and adherent patient.

This will be achieved through:

- Primary identification of high-risk patients within families and referral to PHC facility
- Support to stable chronic patients already well-established on treatment and down-referred to PHC ward based outreach team through the following:
  - point of care testing (blood pressure and blood sugar monitoring assistance) by CHWs at the patient's home
  - medication delivery to the patient (via a courier system, NGOs or CHWs).
- Health promotion and education by the WBOT at the individual, family and community level
- Establishment of age appropriate support groups for a specific or a combination of chronic diseases to maintain and strengthen patient's control of their condition and health.

This section of the manual describes the roles of the community health workers and provides an explanation of the steps to be followed in down referring the patient from the PHC facility to the CHW and the tasks to be fulfilled by the CHWs.

Figure 1: ICDM IMPLEMENTATION APPROACH

ROLE OF THE COMMUNITY HEALTH WORKERS

- The CHW is part of the PHC ward based outreach team.
- The CHW will serve as a link between the PHC facility and the community.
- The CHW will provide health education and promotion with respect to reducing the risk factors for developing chronic diseases and to prevent complications from the existing disease condition(s). This will include, but is not limited to:
    - Healthy eating habits
    - Active living through appropriate exercises
    - Reduction in tobacco and snuf use
    - Decrease in alcohol intake
    - Reduction in salt intake
    - Reduction of risk taking behaviour for sexual activity
- The CHW will conduct screening of all high-risk individuals in a family and early referral of patients for diagnosis and treatment.
- The CHW will offer point of care testing for stable down-referred patients during home visit. This will include:
    - Blood pressure measurements
    - Blood sugar screening.
- The CHW will also:
    - Screen for symptoms of TB
    - Perform provider and client initiated counselling for HIV.
- The CHW will serve as a medicine courier in certain circumstances.

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

- Once the patient is classified as stable:
    - The patient's name, address and fie number should be entered into the down referral diary
    - The patients address should be mapped with the PHC ward based outreach team leader and specifically the responsible CHW allocated to cover that locality
    - Ideally, the patient should be introduced to the CHW at the facility, so that a communication channel can be opened, but if this is not possible, then the patient should be provided with the CHW's name and contact details
    - The patient should be asked about the most convenient time and day for the CHW to visit
    - The latest date that the patient should receive a refill of medication should be entered into the diary
    - The patient should be provided with the clinic number and contact numbers for any emergencies.

DAILY ROUTINE FOR CHWS

- Depending on the internal arrangements, the CHWs should report daily either to the clinic or to the WBOT team leader
- During this meeting the CHWs should provide a brief report of the previous day's work and also provide the records of all patients/households visited to the PHC nurse
- The PHC nurse should provide the CHWs with the predispensed medication for the patients on the list for visits on that day, as well as relevant recording tools.

TOOL 30

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

- **CHW's activities with respect to ICDM**
  - The CHW should proceed with the schedule for the day.
  - The CHW should complete the patient's record during the visit to the patient's home.
  - The CHW should provide point of care testing of blood pressure and blood glucose, where necessary.
  - Should any of the readings be abnormal, the CHW should repeat the measurement after 10 minutes.
  - If it is still abnormal, then the patient should be referred to the WBOT leader or to the facility and this should be recorded in the chart.
  - If all the measurements are normal and the patient has no complications, the pre-dispensed medication package should be opened and the patient should check the medication against the prescription and sign the acknowledgement of receipt attached to the packet.

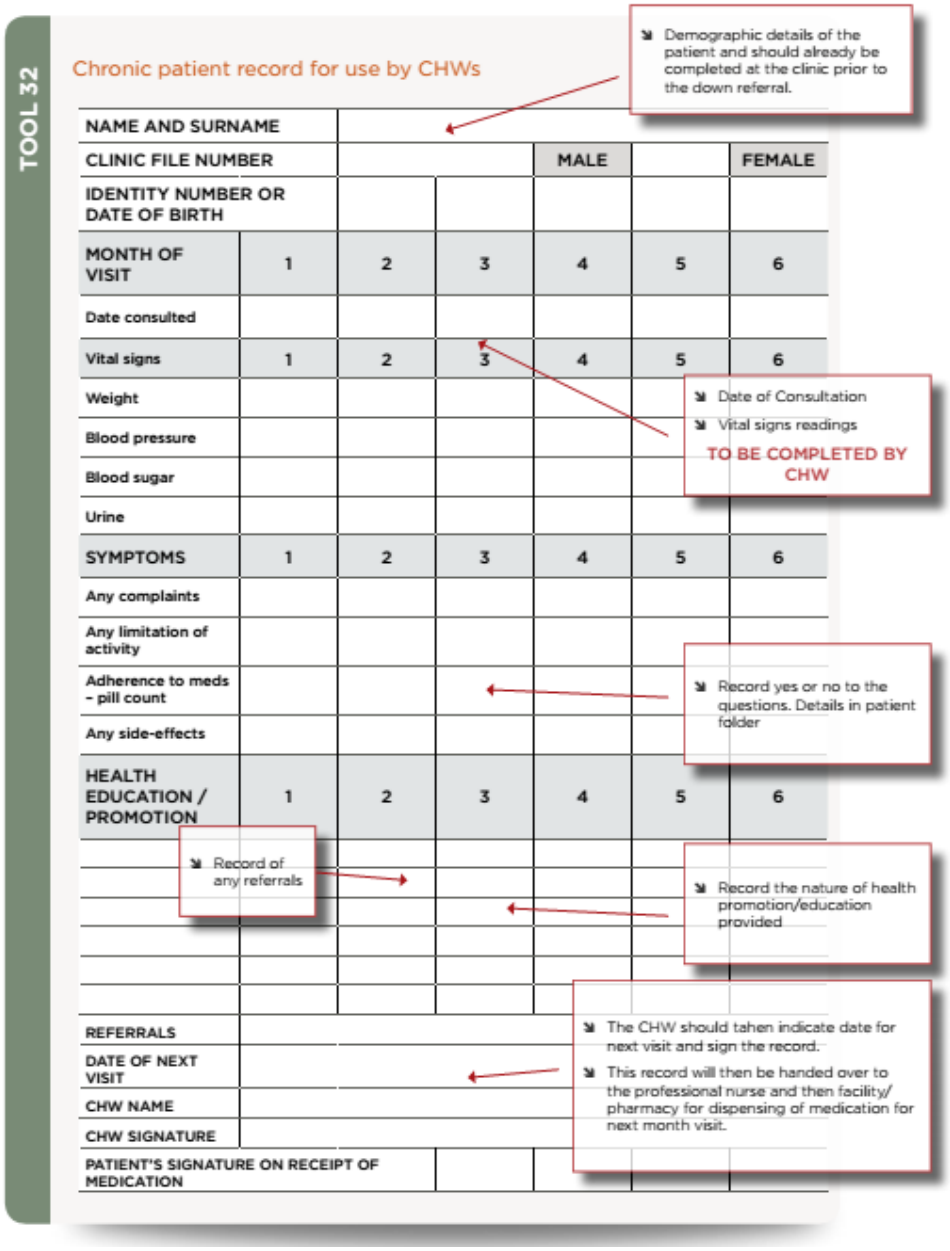
TOOL 31

Tool for acknowledging receipt of medication by patient

NAME and SURNAME					
CLINIC FILE NUMBER					
IDENTITY NUMBER OR DATE OF BIRTH					
MONTH IN SCHEDULE					
DATE OF MEDICATION DELIVERY					
DISPENSER'S SIGNATURE (TO BE COMPLETED AFTER CHECKING, PLACING LABEL AND SEALING PACKET)					
CHWS SIGNATURE ON RECEIPT OF MEDICATION (SEALED BAG)					
PATIENTS SIGNATURE ON OPENING OF SEALED BAG AND CHECKING MEDICATION					
MEDICATION NOT DELIVERED					

➢ **Completion of the chronic patient record by the CHW**

- A summary patient record to ensure continuity of care has been designed for completion by the CHW.
- Medication list should be completed at facility level and the CHW will tick against the medication provided to the patient.



TOOL 32

Chronic patient record for use by CHWs

POPULATION LEVEL AWARENESS AND SCREENING

The WBOTs should play a critical role in raising the level of awareness of chronic diseases at a population level.

Primary prevention is most successful if be conducted at a population level to increase awareness about the social determinants of health and their direct impact on the development of chronic diseases.

This can only be achieved through the participation of the WBOTs in awareness campaigns that may be organised to coincide with specific events within the health calendar.

Social marketing should be used at sports and religious events to raise awareness about chronic conditions.

Screening services should be provided during special events or at strategic points to identify asymptomatic patients or to identify at risk individuals and refer them appropriately.

ISHTs will primarily conduct health education and awareness campaigns at school level and provide screening services to assist with the early detection of chronic diseases and the appropriate referral of these high-risk patients.

ANNEXURE 20- Check list for ICSM compliant package of clinic guidelines

Scoring: In column for Score mark as follow: present = 1; not present =0

Item	Score
Primary Care 101 guidelines – v2 2013/14	
Standard Treatment Guidelines and Essential Medicine List for Primary Health Care -2008	
Standard Treatment Guidelines and Essential Medicine List for Hospitals - 2012	
Standard Treatment Guidelines and Essential Medicine List for Paediatrics – 2013	
Integrated Management of Childhood illness Chart Booklet- 2011	
Newborn Care Charts Management of Sick and Small Newborns in Hospital SSN Version 1- 2009	
Total score	**/6**
Percentage (Score/6)*100	**%**

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

ANNEXURE 21- On-site Training Attendance Register

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

primary care 101

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

ANNEXURE 22- Personal Protective Clothing Catalogue

Scoring: In column for Score mark as follow if appropriate protective clothing is in stock and is worn by staff: present/worn = 1; not present/not worn = 0; Not applicable = NA

Item	Score
Gloves – Non sterile	
Gloves - Sterile	
Long sleeve gowns/disposable aprons	
Surgical masks (face covers)	
Goggles	
Face shields (visors) (for CHC theatre)	
Total score	
Maximum possible score (sum of all scores (6) minus the ones marked NA)	
Percentage (Score/Maximum possible score)*100	**%**

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

ANNEXURE 23- Appropriate Use of Linen

According the NATIONAL INFECTION PREVENTION AND CONTROL POLICY & STRATEGY of April 2007. (Document is up for review)

PATIENTS' LINEN (extracted from the Cleanliness Guidelines- March 2015 (Draft))

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

Basic principles of management of linen.

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

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

Hands must always be cleaned before handling clean linen. Since dirty linen is always heavily contaminated with a wide variety of micro-organisms, it should always be

handled with care to prevent cross contamination. The movement of clean and dirty linen from the point of use to the processing area and back is shown in the figure 1 below. Green coloured circles depict clean linen while the red coloured circle depicts dirty linen.

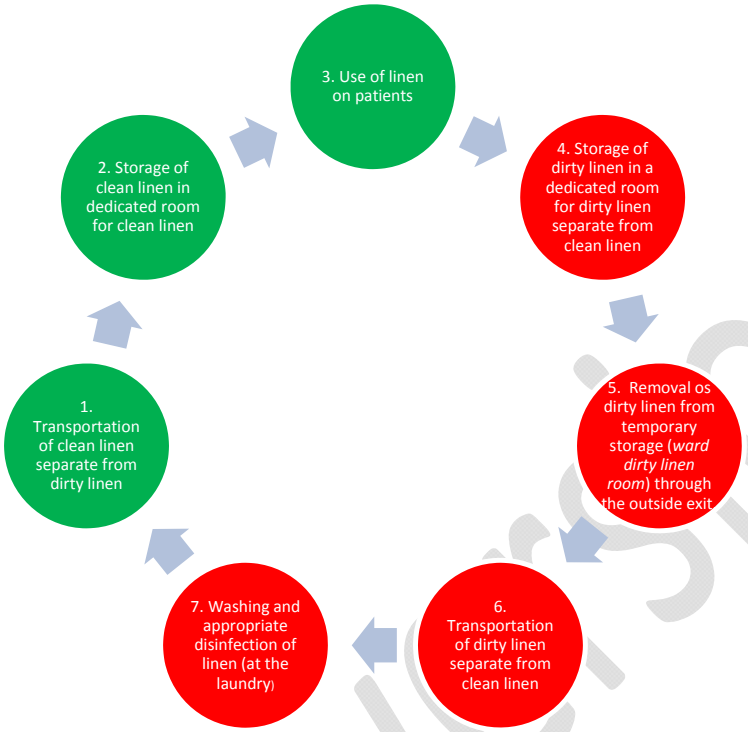


Figure 1: Linen process

Standard operating procedure for handling dirty linen.

- Wear gloves and plastic apron when handling soiled, infectious or infested linen and gloves. NB! There is no need to wear gloves when handling used, dry linen.
- Move canvass trolley for dirty linen to the foot end of the patient bed, examination table or operating table.
- With a gloved hand, remove foreign objects such as dressings, sticky tape, instruments, sharps or food stuff on the linen and dispose them separate from the linen – human excreta and any other discharges may not be removed from the linen while in the ward or service area but are rather sent to the laundry in a separate properly labeled plastic bag e.g. 'Sluice'.
- Do not shake dirty linen.
- Roll the linen inside out towards the foot end of the bed, bundle and place into the appropriate coloured canvass bag while ensuring that it does not come into contact with your clothing.

- Transfer the linen directly from there into the canvass bag on the trolley. Do not carry dirty linen to the dirty linen room or place it on other surface as it will contaminate the protective clothing or the surfaces onto which it is placed.
- Close the bag when it is three quarter full then wheel it to the temporary storage room. Infectious linen is closed immediately and wheeled to the temporary storage room.
- Label the canvass bag containing the linen with the date and the ward, unit or clinic name.
- In case where the linen is infested place it in a plastic bag, place additional label i.e. 'infested linen' or 'pest control' and immediately call the pest control department to treat the linen before sending it to the laundry.
- Wash or spray hands with a disinfectant after handling dirty linen including when moving from one patient's bed to another when making beds.

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

ANNEXURE 24- Health Facility Waste Segregation and Colour Coding

With reference to the Cleanliness Guidelines, March 2015 (draft), pg 55-56, Section 4.2

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

Table 1: Colour coding of waste containers

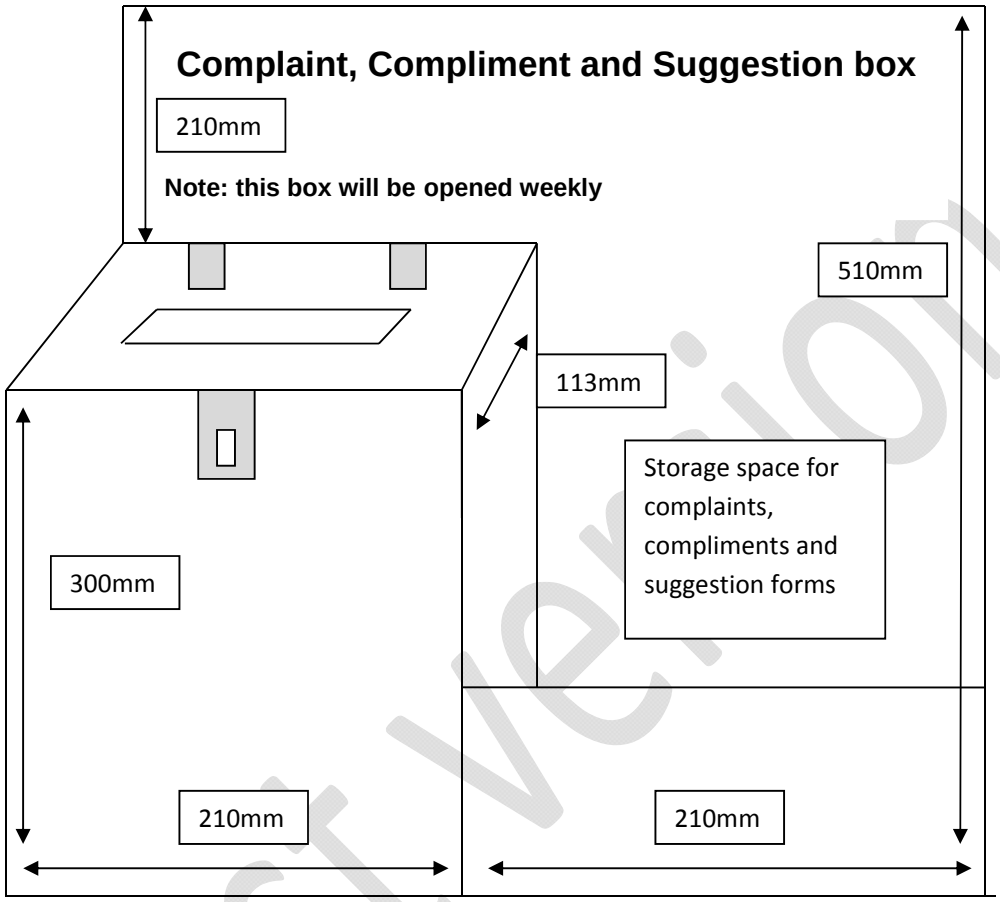
CATEGORY	EXAMPLES	COLOUR	DESTINATION
Category A	Paper, cardboard, yard clippings, wood or similar materials, fruit and food containers. Office papers, wrapping papers.	Black / transparent	Recycling / incineration.
	Leftover food from patients and kitchen and this includes peels from vegetables and fruits.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

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

ANNEXURE 25- Waiting Time Survey Tool

Condition for Which Patient Attending		Acute	Chronic	Mother and child
1	Time the Patient enters clinic			
2	Time the Patient is registered/ allocated card			
3	Time the Patient completed vital signs			
4	Time the Patient starts 1st consultation			
5	Time the Patient completed 1st consultation			
6	Time the Patient started 2nd consultation (If referred to another service)			
7	Time the Patient completed 2nd consultation (if referred)			
8	Time the Patient departs clinic (the last point of contact with service provision)			

ANNEXURE 26- Specifications for Complaint, Compliment and Suggestion Boxes



Specifications

Material	Perspexs, 5mm thick
Colour	Avocado green
Hinges and hook and eye	Perspexs
Label	Printed in dark green text – Font size: "Complaint, compliment and suggestion box" – Arial 72 "Note: this box will be opened weekly" – Arial 32
Lock	Lock with number sequence to lock
Mounted	Must be mounted onto the wall, 1.2m above the ground.

ANNEXURE 27- Complaints, Compliments and Suggestion Form

Date completed	

Ref no	**(office use)**

Details of the person lodging a complaint or recording a compliment or suggestion		
Surname		
First Name		
Contact details	Cell number	
	Postal address	
	Physical address	
If you were admitted, the ward number		
Hospital or clinic file number		
If you are lodging a complaint on behalf of someone else, please complete the following:		
Relation to the patient, e.g. mother, etc.		
Patient's Surname		
Patient's First Name		
Contact details of the patient	Cell number	
	Postal address	
	Physical address	
If patient was admitted, the ward number		
Patient's hospital or clinic file number		

Please describe the incident or give a compliment or make a suggestion.
* Where possible also record the staff involved and department where the incident took place.

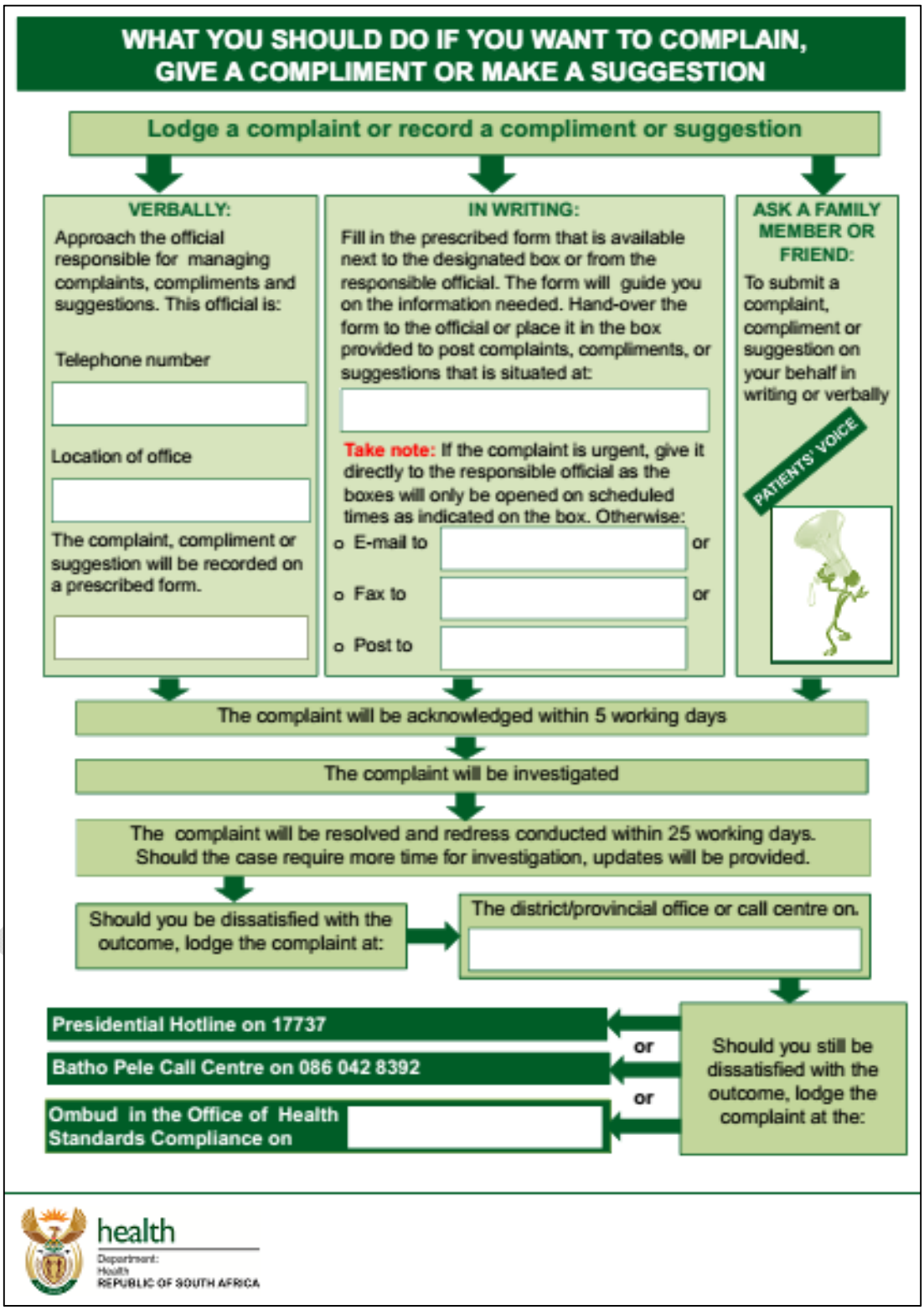
Date on which the incident took place:	

_____ _____

Signature of person lodging a complaint or recording a compliment or suggestion

Signature of patient

ANNEXURE 28- Complaints, Compliments and Suggestions Poster



ANNEXURE 29- Catagories for Complaints According to the Sub-domains and Standtrds of the NCSs

Facility Name/Province:	**Financial Year:**													
Sub-domain	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**TOT**	**%***
1.1 Respect and dignity														
1.2 Access to information for patients														
1.3 Physical access														
1.4 Continuity of care														
1.5.1 Waiting time and queues are managed														
1.5.2 Waiting list for operations are kept short														
1.6 Emergency care														
1.8 Complaints management														
2.1 Patient care														
2.2 Clinical managaement of priority health conditions														
2.4.2 Pregnant mothers, children, mentally ill & elderly pt's receives special attention														
2.4.3 Patients undergoing high risk procedures are protected														
2.6 Infection prevention and control														
3.1.2 Medicines and medical supplies are in stock														
3.1.4 Medicines correctly prescribed/patient														

educated														
3.2 Diagnostic services														
3.3 Therapeutic and support services														
3.4 Health technology														
3.7 Clinical Efficiency Management														
6.7 Medical Records														
7.1 Buildings and grounds														
7.3 Safe and secure environment														
7.4 Hygiene and cleanliness														
7.6 Linen and laundry														
7.7 Food services														
8 Other														
GRAND TOTAL														

*Calculate: (Number received per category/Grand Total0*100 (e.g. 20 complaints catacorised under Respect and dignity. Grand Total for number of complaints recived is 40: 20/40*100= 50%)

ANNEXURE 30- Monthly Complaints: Statistical data

FORMAT FOR SUBMITTING STATISTICAL DATA ON COMPLAINTS

Name of Establishment/Province: _____

Financial Year: _____

Column Name	A	B	C	D	E
Month:	**# Complaints Received**	**# Complaints Resolved**	**% Complaints Resolved (Column B/ Column A)**	**# Complaints resolved within 25 Working days**	**% Complaints resolved within 25 working days (Column D/ Column B)**
April					
May					
June					
July					
Aug					
Sept					
Oct					
Nov					
Dec					
Jan					
Feb					
March					
TOTAL/AVG					

ANNEXURE 31- Temperature Control Chart: Medicine Room

ROOM TEMPERATURE MONITORING CHART

FACILITY: _____

YEAR: _____

Record the temperature in the morning and in the afternoon.

Report if room temperature is above 25 degree!

	(MONTH)			(MONTH)			(MONTH)		
DATE	**AM**	**PM**	**SIGN**	**AM**	**PM**	**SIGN**	**AM**	**PM**	**SIGN**
1									
2									
3									
4									
5									
6									
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ANNEXURE 32- Contingency Plan: Refrigerator or Medicine Storage Room

Maintenance and monitoring of the refrigerators:

- Ensure a regular supply of gas or paraffin for the refrigerator, if applicable.
- For electric refrigerators, ensure that back-up generators are available
- For solar-powered refrigerators, check battery level regularly.
- Have a cooler box and frozen ice packs ready at all times in case of power failure.
- Equip each refrigerator with a working dial thermometer. Preferable is an electronic monitoring and recording device linked to an alarm system.
- Hang the thermometer upright in the centre of the fridge storage area.
- Read the temperature twice daily and record it the official temperature chart attached to the outside of the refrigerator.
- If the temperature is below $2^{O}C$ or above $8^{O}C$, report to the pharmacist
- Every fridge to have a separate electric socket.

Defrosting and cleaning of refrigerators:

- Defrost the refrigerator at least once a month, or when the ice layer in the freezing section is more than 0.5 cm thick.
- If frequent defrosting is needed, check the door seals.
- Place all vaccines and ice packs in cooler boxes before turning off the refrigerator to maintain the cold chain.
- Turn off the refrigerator.
- To get the ice to melt, leave the door of the refrigerator open, or place a bowl of hot water in the freezing section. Do not use sharp objects to scrape off the ice.
- When the ice has melted, clean the inside of the refrigerator and wipe it dry.
- Clean the door gasket (seal) carefully, especially along the bottom edge on upright refrigerators. Check that the fridge door closes and seals tightly.
- Clean the condenser coil on the back of the refrigerator and dust the compressor.
- Turn the refrigerator back on.
- Pack vaccines into the refrigerator when the temperature is below 8°C.
- A back-up generator must be available and functional to ensure a continuous power supply
- In the event of a power failure: All facilities to have a written contingency plan e.g. Identify other fridges in the area which are available.
- Keep the refrigerator closed until the power supply is restored or a second working fridge is available.
- If an alternative refrigerator is available and the power failure persists after 30 minutes, transfer the vaccines to the alternative fridge.

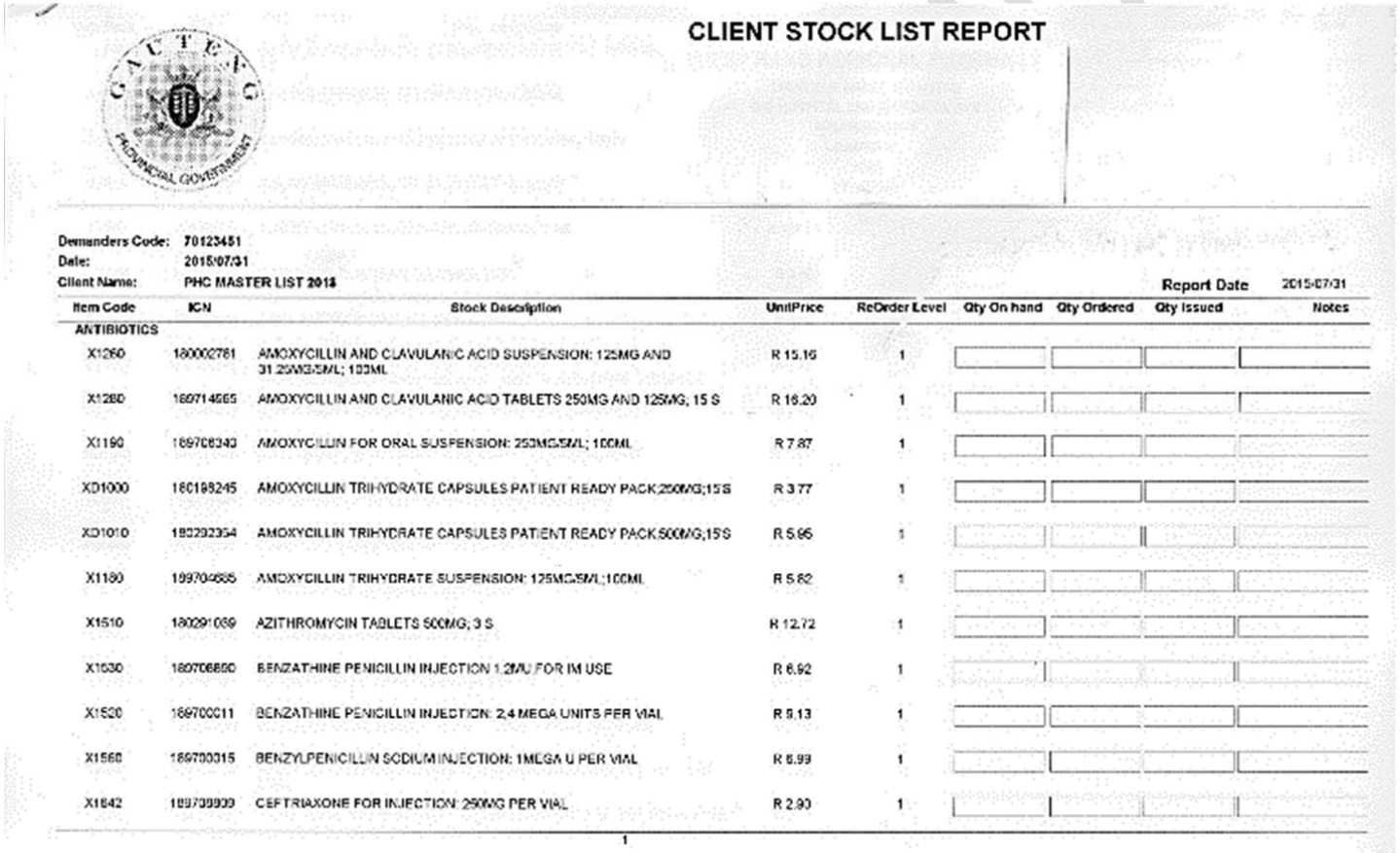
Power failure

- Do not open the refrigerator until the power supply is restored
- Report the following to the pharmacist:
- Duration of power failure.
- Temperature inside the refrigerator when power is reconnected;
- Quantity by type and presentation of vaccines affected;

- Expiry dates of vaccines affected;
- Reading from the cold chain monitor card if present;
- State (colour) of the VVM'S on OPV or any other vaccine.
- Determine the damage caused by the power failure.
- Report damaged or expired stock as avoidable wastage.
- Dispose of expired stock according to approved procedures, see SOP: Disposal of expired, unusable stock.

ANNEXURE 33- Prescribed Medicine Request Form

THIS EXAMPLE SHOWS RE-ORDER LEVELS OF 1. LEVELS ARE CLINIC- SPECIFIC AND WILL BE AMMENDED ACCORDINGLY.



CLIENT STOCK LIST REPORT

Demanders Code: 70123451
Date: 2015/07/31
Client Name: PHC MASTER LIST 2015

Report Date 2015/07/31

Item Code	ICN	Stock Description	UnitPrice	ReOrder Level	Qty On hand	Qty Ordered	Qty Issued	Notes
ANTIBIOTICS								
X1260	160002761	AMOXYCILLIN AND CLAVULANIC ACID SUSPENSION: 125MG AND 31.25MG/5ML; 100ML	R 15.16	1				
X1280	160714665	AMOXYCILLIN AND CLAVULANIC ACID TABLETS 250MG AND 125MG; 15 S	R 16.20	1				
X1190	169706340	AMOXYCILLIN FOR ORAL SUSPENSION: 250MG/5ML; 100ML	R 7.87	1				
XD1000	160198245	AMOXYCILLIN TRIHYDRATE CAPSULES PATIENT READY PACK:250MG;15'S	R 3.77	1				
XD1010	160292354	AMOXYCILLIN TRIHYDRATE CAPSULES PATIENT READY PACK:500MG;15'S	R 5.95	1				
X1180	169704685	AMOXYCILLIN TRIHYDRATE SUSPENSION: 125MG/5ML;100ML	R 5.82	1				
X1510	160291069	AZITHROMYCIN TABLETS 500MG; 3 S	R 12.72	1				
X1530	160706860	BENZATHINE PENICILLIN INJECTION 1.2MU FOR IM USE	R 6.92	1				
X1520	169700011	BENZATHINE PENICILLIN INJECTION: 2.4 MEGA UNITS PER VIAL	R 9.13	1				
X1560	169700015	BENZYLPENICILLIN SODIUM INJECTION: 1MEGA U PER VIAL	R 6.99	1				
X1642	169709999	CEFTRIAXONE FOR INJECTION: 250MG PER VIAL	R 2.90	1				

1

ANNEXURE 34- Phone Call Log Form

Name _____ Period _____

Name of Person/Company Called	Phone Number	Date	Time of Call	Length of Call	Purpose of Call	Follow-Up Needed?

ANNEXURE 35- Procedure for Managing Expiration of Medicine

1. On a monthly basis identify expired, excessive, slow moving, unusable and obsolete stock within the pharmacy stores, dispensaries, wards and in any area where medication is kept.
2. For expired, unusable and contaminated stock (S1 – S4)
   Unusable stock is defined as stock that has been damaged, contaminated, was not stored under the recommended storage conditions, declared unsafe for human use or has expired in terms of the open vial (multi-dose vial) policy.
   - Check expiry date upon receipt of stock and during the monthly stock counts.
   - Expired stock must be removed from the usable stock immediately and stored separately and securely until disposed of.
   - Remove items from the shelves in the presence of a witness:
     - Either a pharmacist and pharmacist assistant at a licensed and recorded pharmacy or dispensary;
     - Or a pharmacist assistant and the facility manager or member off health team as delegated at a dispensary or medicine room;
     - Or by two health care team members in a medicine room, consulting room or ward.
   - Medicine destined for destruction must be separated into the following six types and clearly labelled:
     - Solid dosage forms;
     - Creams, ointment and powders;
     - Ampoules and liquids (contained in glass);
     - Aerosols;
     - Radioactive medicines;
     - Cytostatic and cytotoxic medicines and scheduled substances.
   - All expired stock must be recorded on a VA2 and / or VA27. The following information must appear on the Chronological VA2 and / or VA27 (triplicate):
     - Alpha code;
     - Details of the institution;
     - Description of the item;
     - Quantity expired or damaged;
     - Expiry date;
     - Reason for expiry or damage;
     - Value of the expired stock;
     - Signature of person who removed the expired stock and the witness.
   - Expired stock must be clearly marked as “Expired stock, not to be used”
   - Update the stock card (modified VA11) with the expired stock removed and record the new balance, with a clear indication of the date and reason for removal on the stock card (modified VA11).
   - Expired stock returned to the pharmacy store or medicine room, from the wards, clinics or consulting rooms, must be accompanied with the required documentation VA2 and / or VA27 and the expired stock returned is not for credit or exchange.
   - A copy of all documentation must be retained at the both the receiving and the returning site, in a file labelled “expired, obsolete and unusable stock.
   - The expired items must be handled in accordance to the SOP: Management and disposal of expired, obsolete and patient returned medication.
   - The Pharmacy (supplier of stock) within the district, hospital or CHC is required to accept expired and unusable stock from the wards, clinics etc, for destruction purposes only

and reserves the right not to exchange the stock or credit returning site. However arrangements can be made within districts for the clinics to dispose of their own expired stock, but all procedures of this SOP and the SOP: Disposal of expired stock must be adhered to.

- MSD reserves the right not to accept back expired stock from the institutions, unless it was expired on receipt and MSD had been notified.

3. For expired, unusable and contaminated stock (SS5 and S6)
    - All relevant procedures for expired stock schedule 1 to schedule 4, applicable to the SS5 and S6 must be applied
    - Schedule 5 medications should be recorded on a separate VA2 and / or VA 27 as the procedure for destruction for S5 is different from the schedule one to four medicine.
    - Specified Schedule 5 and S6 expired medication should be recorded on a separate VA2 and / or VA27 as the procedure for destruction of the S6 medication is different from schedule one to four medicine and schedule 5 medicines.
    - The quantity of the expired stock removed from the pharmacy store or cupboard must clearly be subtracted, using a red pen, in the specified S5 or S6 register and recorded in the separate expired SS5 and S6 register. This is to ensure that on a daily basis the balance in the SS5 and S6 register does not need to account for expired stock. This will require the signature of the pharmacist responsible for the schedule cupboard and a witness.
    - For expired stock to be returned to the pharmacy within the wards or clinics, check that a corresponding entry in made in the ward or clinic register. All stock received back in the pharmacy must be recorded in the expired stock register for documentation and control purposes.
    - The expired register for the SS5 or S6 medication must contain the following information: date, description of the item, dosage form, expiry date, batch number, pharmacy, ward or clinic where the stock expired, quantity and the reason for destruction if other than expiry.
4. For obsolete (no longer used at the institution)
    - On a monthly basis check for obsolete stock.
    - Prepare a list of items and forward to the pharmacist.
    - The pharmacist will identify other institutions or areas, which may be able to use the stock.
    - The pharmacist can request MSD to assist with identifying which institutions still use the item no longer used at your facility.
    - The pharmacist will update the overstock item list and circulate to all pharmacy managers via email, to inform other institutions of stock available for redistribution.
    - The pharmacist will arrange for the transfer of stock, using the VA5 form, to an institution where the stock can be used.
    - Update the stock card (modified VA11) accordingly with the transfer out of stock.
    - Ensure that the stock card (modified VA11) is clearly marked “Obsolete Stock” to prevent reordering of items not used at the institution.
    - Obsolete stock returned to the pharmacy from the wards or clinics must be accompanied with the required documentation (VA2) and the obsolete stock returned is not for credit or exchange.
    - MSD reserves the right not to accept back obsolete stock from the institutions.
5. For excess, slow moving items or short dated stock
    - Short dated stock which can be used by the facility must be clearly marked and put in front of the all the available stock to ensure that it is used first.
    - Short dated stock (within 4 months of expiry) which will not be used must be clearly identified and marked for redistributed to high usage areas or institutions.

- Prepare a list of all stock which has a shelf life shorter than four months, excessive stock and slow moving stock and for forward to the pharmacist.
- The pharmacist will identify other institutions that may be able to use the stock.
- The pharmacist may request MSD to assist with identifying which institutions still use the item no longer used at your facility.
- The pharmacist will update the overstock item list and circulate to all pharmacy managers via email, to inform other institutions of stock available for redistribution.
- The pharmacist will arrange for the transfer of stock to another institution, using the VA5 form.
- Slow-moving and obsolete stock should be identified from the modified VA11 by checking the stock holding, the frequency and quantity of demands (stock on hand divided by average monthly consumption). This will give the total stock holding in months and the pharmacist may then decide on the quantity for redistribution.
- Overstocking or understocking requires the re-order levels of the medicine to be recalculated in line with usage.
- Excess, slow moving or short dated stock returned to the pharmacy store from the wards or clinics must be accompanied with the required documentation (VA2). The stock returned is not for credit or exchange as the stock may be deemed unfit for further use, at the discretion of the pharmacist
- MSD reserves the right not to accept back excess, slow moving or short dated stock over ordered i.e. by repeated orders due to dues out of an item.

Policy, references and resource material includes:
Pharmacy Act (Act 53 of 1974) and Regulations as amended.
Medicine and Related Substances Act (Act 101 of 1965), Regulations and Guidelines as amended.
Public Finance Management Act (Act 1 of 1999).
Good Pharmacy Practice in South Africa, Latest Edition.
Provisioning Administration Manual (PAS Manual).

ANNEXURE 36- Surgical Supplies (Consumables)

Scoring: In column for Score mark as follow: present = 1; not present =0

SURGICAL SUPPLIES			
Item	**Score**	**Item**	**Score**
Admin set blood 10 drops/ml /pack		Haemolysis applicator sticks	
Admin set 20 drops/ml 1.8m /pack		HB meter clip	
Admin set pead 60 drops/ml 1.8m /pack		Infusion set 19g	
Amnihook curved /pack		Infusion set 21g	
Aquapack respiflo 2325 /pack		Infusion set 23g	
Blade razor disposable 5`s/pack		Infusion set ivac 590	
Blade stitch cutter sterile short /pack		Jelco/delta ven t 18g green /box	
Blood collecting vacutainer 21g		Jelco/delta ven t 20g pink /box	
Blood lancets (haemolance)		Jelco/delta ven t 22g blue /box	
Bulldogs		Mask oxy adult 24% with tube	
Cannula nasal adult		Mask oxy adult 28% with tube	
Cannula nasal paed		Mask oxy adult 35% with tube	
Cannula nasal infant		Mask oxy adult 40% with tube	
Catheter cyctofix adult fg 10 120mm		Mask oxy paeds 24% with tube	
Catheter cyctofix pead fg10 80mm		Mask oxy paeds 28% with tube	
Catheter foley 8f silicone /tube		Mask surgical face with ear ties /box	
Catheter foley 10f silicone /tube		Microscope slides	
Catheter foley 12f elatome /tube		Nebulizer face mask adult	
Catheter foley 14f elatome /tube		Nebulizer face mask child	
Catheter foley 14f silicone /tube		Needle and cartridges	
Catheter foley 16f elatome /tube		Needle hypod 19g /box	
Catheter foley 16f silicone /tube		Needle hypod 21g /box	
Catheter foley 18f elatome /tube		Needle hypod 22g	
Catheter foley 18f silicone /tube		Needle hypod 23g /box	
Catheter foley 20f elatome /tube		Needle hypod 25g /box	
Catheter foley 20f silicone /tube		Needle insulin 30g (novofine) /box	
Catheter foley 22f elatome /tube		Sheath incontinence 25mm	
Catheter nelaton 400mm 08f		Sheath incontinence 30mm	
Catheter nelaton 400mm 10f		Sheath incontinence 35mm	
Catheter nelaton 400mm 12f		Silver nit/pot nitrate stick / stick	
Catheter nelaton 400mm 14f		Spatula vaginal aylesburg	
Catheter nelaton 400mm 16f		Suture chromic g1 1/2 rc40 75cm (w770)	
Catheter suction resp 500mm 06f		Suture chromic g2/0 1/2 rc36 90cm (816g)	
Catheter suction resp 500mm 08f		Suture nylon g2/0 3/8 rc26 45cm (664g)	
Catheter suction resp 500mm 10f		Suture nylon g2/0 3/8 rc39 75cm (w736)	
Catheter suction resp 500mm 12f		Suture nylon g3/0 3/8 rc24 45cm (663g)	
Catheter suction resp 500mm 14f		Suture nylon g4/0 3/8 rc19 45cm (662g)	
Catheter thoracic silicone st20		Syringe hypod insulin 100u/ml 27g /box	
Catheter thoracic silicone st24		Syringe hypod luer 3-part 10ml/box	
Catheter thoracic silicone st28		Syringe hypod luer 3-part 20ml	
Catheter thoracic silicone st30		Syringe hypod luer 3-part 2ml /box	
Catheter thoracic silicone st32		Syringe hypod luer 3-part 5ml /box	
Chamber glass-grooved white		Syringe hypod tuberculin 25g /box	
Cover glass-plain green		Thermometer clinical celcius oral	
Drainage sys chest u/water adult		Tongue depresser wood	
Drainage bag urine leg 750ml		Tube duodenal ryles 16f	
Electrodes adult		Tube duodenal ryles 18f	
Feeding tube 600mm fg5		Tube et cuffless (oral/nasal) 2.0mm	
Feeding tube 600mm fg8		Tube et cuffless (oral/nasal) 2.5mm	
Feeding tube 1000mm fg10		Tube et cuffless (oral/nasal) 3.0mm	
Gloves exam n/sterile latex large /box		Tube et cuffless (oral/nasal) 6.0mm	
Gloves exam n/sterile latex medium /box		Tube et cuffless (oral/nasal) 6.5mm	
Gloves exam n/sterile latex small /box		Tube stomach washout 24fg	
Gloves surg latex sz 6 /box		Tube,stomach washout 26fg	
Gloves surg latex sz 6.5 /box		Tube,stomach washout 28fg	

Gloves surg latex sz 7 /box		Tube stomach washout 30fg	
Gloves surg latex sz 7.5 /box		Ultrasound gel medium viscosit	
Gloves surg latex sz 8 pdr/free /box		Urine drainage bag type 2 with tap	
Guedel airway size 1			
Guedel airway size 00			
Guedel airway size 3			
Guedel airway size 4			
Sub Total 1 for surgical supplies		**Sub Total 2 for surgical supplies**	
Total Score for surgical supplies (Total of Sub Total 1 and 2)			**/120**
Percentage for surgical supplies (Total score/120)*100			

DRESSINGS SUPPLIES

ITEM	Pack size	Score
Bactrigras 100x100mm /box	10	
Bandage elastoplast 25mmx4.5m /roll		
Bandage elastoplast 75mmx4.5m /roll	1	
Bandage crepe 75mm /roll	1	
Bandage crepe 150mm /roll	1	
Cotton ear buds /box	100	
Cotton wool balls 1g 500`s	1	
Elastomesh size 2 7432 /box	1	
Elastomesh size 1 7431 /box	1	
Elastomesh size 5 7435 /box	1	
Elastomesh size 6 7436 /box	1	
Gauze paraffin 100x100 /box	10	
Gauze abs grade 1 burn 225x225x16 /pack	100	
Gauze swabs plain n/s 100x100x8ply/pack	100	
Padding cast ortho 50mmx3m /roll	1	
Padding cast ortho 100mmx3m /roll	1	
Padding cast ortho 150mmx3m /roll	1	
Plaster of paris bandage 100mm /roll	1	
Plaster of paris bandage 150mm /roll	1	
Plaster of paris bandage 200mm /roll	1	
Sanitary towels maternity /pack	12	
Skin traction kit - adult (elast 0468)	1	
Skin traction kit - child (elast 0469)	1	
Sodium carboxymethyl cel (intrasite) 15g	1	
Sockinette 100mm /roll	1	
Tape adh micro-porous 50mmx5m /roll	1	
Tape adh zinc oxide 50mmx5m /roll	1	
Tray dressing basic small (surgipak)	1	
Webcol 24x30 1ply /box	200	
Total Score for dressing supplies		**/29**
Percentage for dressing supplies (Total score/29)*100		
Grand total for surgical and dressing supplies		
Percentage scored for surgical and dressing supplies (Grand Total/149)*100		**%**

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

ANNEXURE 37- Laboratory equipment and Consumables

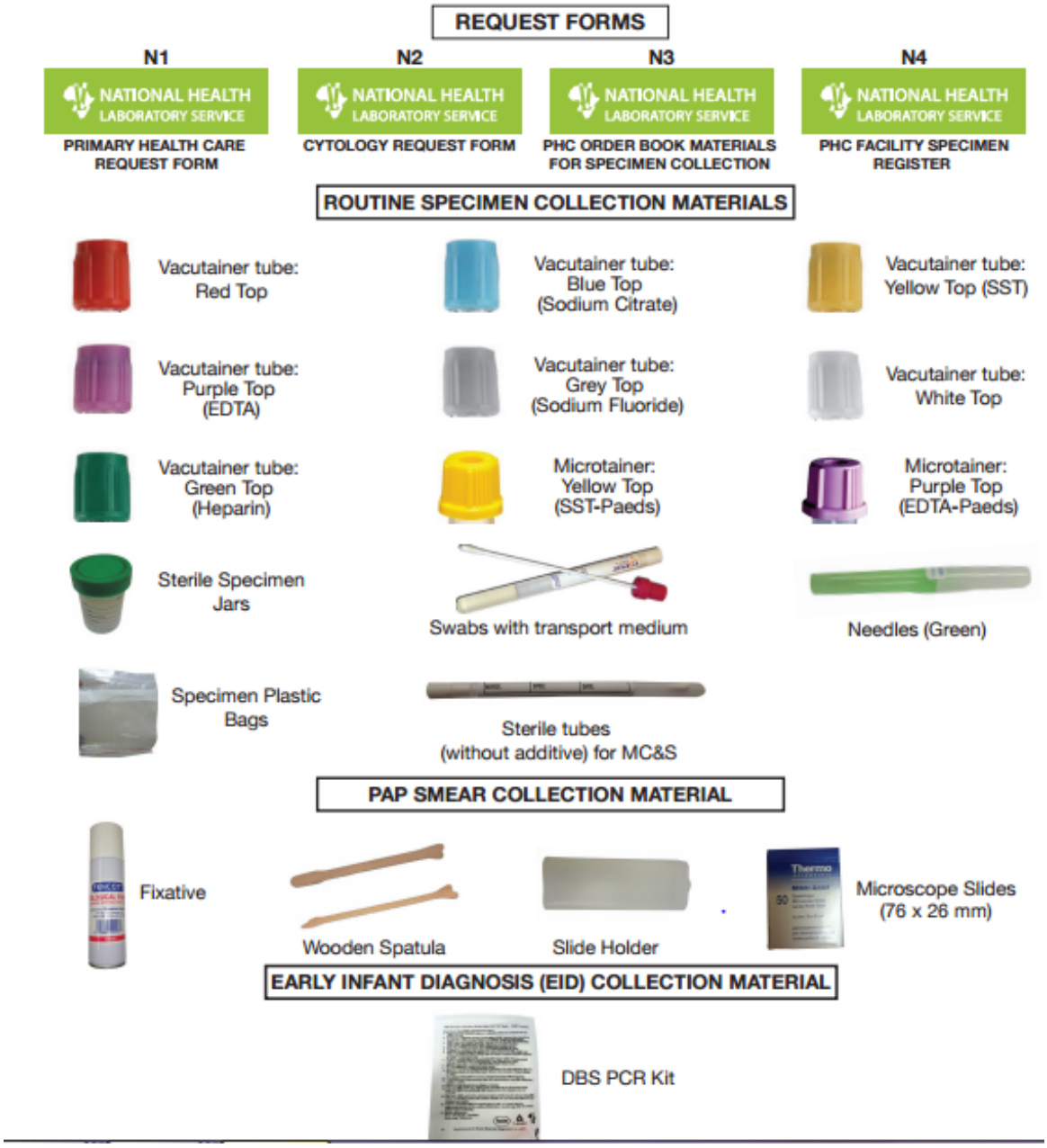
Scoring: In column for Score mark as follow: present and functional = 1; not present or not functional =0

Item	Score
Hb meter	
Blood glucometer	
Glass slides	
Lancets	
Blood glucose strips	
Urine dipsticks	
Urine specimen flasks	
Spare batteries	
Malaria rapid test	
Rapid HIV test	
Rh 'D' (Rhesus factor) test	
Total laboratory equipment and consumables	**/11**
NHLS consumables	
Request forms	
PHC Request Form	
Cytology Request Form	
PHC Order Book Material for specimen collection	
PHC Facility Specimen Register	
Routine Specimen Collection Materials	
Vacutainer tube: Red Top	
Vacutainer tube: Blue Top (Sodium Citrate)	
Vacutainer tube: Purple Top (EDTA)	

Vacutainer tube: Yellow Top (SST)	
Vacutainer tube: Grey Top (Sodium Fluoride)	
Vacutainer tube: White Top	
Vacutainer tube: Green (Heparin)	
Microtainer: Yellow (SST-Paeds)	
Microtainer: Purple (EDTA Paeds)	
Sterile Tubes (without additive) for MC&S	
Sterile specimen jars	
Swabs with transport medium	
Needles (Green)	
Specimen Plastic Bags	
Pap smear collection materials	
Fixative Wooden spatula	
Slide holder	
Microscope Slides	
Early Infant diagnosis (EID) collection material	
DBS PCR Kit	
Total Score NHLS consumables	**/22**
Grand total (Total score laboratory equipment and consumables + total score NHLS consumables)	**/33**
Percentage (Grand total/33)*100)	**%**

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

Illustration of NHL consumables



Request form for NHLS consumables

(Name of local laboratory)		NATIONAL HEALTH LABORATORY SERVICE	
Health Facility Name:		No: 0000001	
Name of the requestor:			
Contact Details:	Address:	Facility Manager Signature:	
	Tel:	Date requested:	REQUEST FORM N3

PHC Specimen Collection Material Order Form

Category	Description	Unit of Measure	Stock on Hand	Quantity Requested	Quantity Approved in Laboratory (Initial)	Quantity Supplied (Link to exemplar)	Receipt acknowledgement
Request Forms	PHC Request Form N1	50 Forms per book					
	Cytology Request Form N2	50 Forms per book					
	PHC Order Book Material for specimen collection N3	25 Sets per book					
	PHC Facility Specimen Register N4	50 Forms per book					
Routine Specimen Collection Materials	Vacutainer tubes Red Top	Tube					
	Vacutainer tubes Blue Top (Sodium Citrate)	Tube					
	Vacutainer tubes Yellow Top (SST)	Tube					
	Vacutainer tubes Purple Top (EDTA)	Tube					
	Vacutainer tubes Grey Top (Sodium Fluoride)	Tube					
	Vacutainer tubes White Top	Tube					
	Vacutainer tubes Green (Heparin)	Tube					
	Microtainer Yellow (SST/Paxia)	Tube					
	Microtainer Purple (EDTA Paxia)	Tube					
	Sterile specimen jars	Jars					
	Sterile Tubes (without additive) for MCA3	Tubes					
	Swabs with transport medium	Swab					
	Needles (Green)	Box (100)					
	Specimen Plastic Bags	Pad (50)					
Pap smear collection materials	Fixative	Bottle					
	Wooden spatula	Pack (50)					
	Slide holder	Each					
	Microscope Slides	Pack (50)					
Early Infant diagnosis (EID) collection material	DBS FORMS	100 Kits					

Motivation for additional specimen collection material, e.g. campaign

TO BE COMPLETED BY LABORATORY STAFF AND COURIERS

Collection by Courier		Despatch by Laboratory		Receipt by Laboratory		Receipt by Facility	
Name		Name		Name		Name	
Signature		Signature		Signature		Signature	
Date		Date		Date		Date	

ANNEXURE 38- Laboratory Result Tracking

There are a number of mechanisms for a health facility to receive laboratory results:-

- Delivery of printed patient results by the courier: This is the primary mechanism for receiving results. If however the printed laboratory results have not yet been delivered by the courier, please use one of the mechanisms below.
- Using the SMS printer to access laboratory results: The request form barcode can be used to access laboratory results using the SMS printer.
- Using the internet results portal to access laboratory results (requires internet): The results portal is available provided you have a computer with internet access (decent bandwidth required). Additionally, users need to be registered to use this service
- The last resort would be to call your local laboratory to request the patient's results.

The results of the laboratory results must be tracked to prevent a failure in the system.

Laboratory Results Tracking Form

Facility Name: _____

Facility Manager: _____

Date Form Started: _____

Patient Code	Patient Name	Date Sample Taken	Date Sample Collected	Collect By	Date Results Received	Received By	Follow-up Call

ANNEXURE 39- Form E3: Request for the Advertisement and Filling of a Post

E3

DEPARTMENT OF HEALTH

REQUEST FOR THE ADVERTISEMENT AND FILLING OF A POST

THIS REQUEST MUST BE ACCOMPANIED BY A JOB DESCRIPTION FOR THE RELEVANT POST

VERIFICATION OF FUNDS BY SUB-PROGRAMME MANAGER AND PROGRAMME MANAGER ON PAGE 4

---

1. POST DETAILS

(Please mark with X in the applicable block)

• ***THIS POST IS VACANT ON THE POST ESTABLISHMENT, FUNDS ARE AVAILABLE. THE POST NEEDS TO BE ADVERTISED AND FILLED.***	
• ***THIS IS A NEW POST, HAS BEEN APPROVED FOR CREATION AND FUNDS ARE AVAILABLE FOR ADVERTISEMENT AND FILLING (PLEASE ATTACH A COPY OF THE APPROVED WORK STUDY REPORT).***	

a) Post Job Title (To correspond with the Post Job Title on the post establishment, Full rank): _____

b) CORE Description: _____

c) Post Class: _____

d) Post Number _____

e) Component Number: _____

f) Chief Directorate: _____

g) Directorate/Sub-directorate/ Division: _____

h) Pay Point: _____

i) Responsibility: _____

j) Objective: _____

k) Item: _____

_____

The reason for the post being vacant is (Please indicate previous incumbent of the relevant post):_____

DEPUTY-DIRECTOR **DIRECTOR:**

DATE: **DATE:**

CONFIRMATION AND VERIFICATION BY THE SUB-DIRECTORATE: ORGANISATIONAL DEVELOPMENT	
Post is vacant / approved for creation on the post establishment: *Deputy-Director:* *OD: Organizational Development*	*Job Evaluation was done on the post and the post Salary Level is approved on:*

2. REQUEST FOR THE ADVERTISEMENT OF A POST

ALL REQUIREMENTS AND DUTIES MUST CORRESPOND WITH THE JOB DESCRIPTION OF THE POST WHICH SHOULD BE ATTACHED TO THIS FORM

- Qualification Requirements as set in the relevant CORE:
- _____
- Experience requirements _____
- Additional requirements/notes/Recommendations
  _____
  _____
  _____
  _____

Security Clearance is mandatory for all posts:

Please indicate the level of clearance required:	Confidential	Secret	Top Secret
Is Integrity Assessment required?	Yes		No

Is a valid Code B (code 8) driver's licence required?	Yes	No

Contact person _____

Telephone Number _____

Fax Number _____

Media (Newspaper) _____

_____

PLEASE PROVIDE THE DUTIES OF THE POST ON PAGE 5 OF THIS FORM

3. REPRESENTIVITY

The filling of the post will promote representivity	Yes	No

If no, please supply reasons:

_____

The filling of the post will promote representivity in terms of the disabled	Yes	No
Definition: A person with disability has a long-term or permanent impairment or recurring condition or health problem, which needs to be reasonably accommodated on the job and calls for the elimination of barriers in the workplace. The impairment may be of a physical, mental, sensor learning or psychiatric nature which is medically certified.		

REPRESENTIVITY STATUS PER DIRECTORATE REQUESTING ADVERTISEMENT

LEVEL	AFRICAN				COLOURED				INDIAN				WHITE				TOTAL			
	M	D	F	D	M	D	F	D	M	D	F	D	M	D	F	D				
16																				
15																				
14																				
13																				
12																				
11																				
10																				
9																				
8																				
7																				
6																				

5																				
4																				
3																				
2																				
1																				
TOTAL																				

M=Male D=Disabled F=Female

4. APPROVAL BY SUB- PROGRAMME MANAGER AND PROGRAMME MANAGER:

Funds for the **advertising and filling** of the post are available:	Yes	No
Date of latest financial report:	YYYY / MM / DD	

Amount budgeted	Amount spent (Year to date)	Amount available
R	R	R

Please indicate the source of funding:

Voted	Earmarked	Donor

_____

Sub-Programme Manager

Date:

_____

Programme Manager

Date:

5. DUTIES OF THE POST FOR ADVERTISEMENT

(Please note that these should correlate with the ATTACHED Job Description):

ANNEXURE 40- Work Allocation Schedule: Other Staff

Name of Staff Member	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6

ANNEXURE 41- Register to confirm that policies/guidelines/SOP are understood

Policy/guideline/SOP: (insert name of policy/guideline/SOP)

DATE	NAME AND SURNAME	PERSAL NUMBER	SIGNATURE

ANNEXURE 42- Yearly Planner (Example)

2015 ANNUAL PLANNER

	January	February	March	April	May	June	July	August	September	October	November	December
Sunday		1	1								1	
Monday		2	2			1					2	
Tuesday		3	3			2			1		3	1
Wednesday		4	4	1		3	1		2		4	2
Thursday	1	5	5	2		4	2		3	1	5	3
Friday	2	6	6	3	1	5	3		4	2	6	4
Saturday	3	7	7	4	2	6	4	1	5	3	7	5
Sunday	4	8	8	5	3	7	5	2	6	4	8	6
Monday	5	9	9	6	4	8	6	3	7	5	9	7
Tuesday	6	10	10	7	5	9	7	4	8	6	10	8
Wednesday	7	11	11	8	6	10	8	5	9	7	11	9
Thursday	8	12	12	9	7	11	9	6	10	8	12	10
Friday	9	13	13	10	8	12	10	7	11	9	13	11
Saturday	10	14	14	11	9	13	11	8	12	10	14	12
Sunday	11	15	15	12	10	14	12	9	13	11	15	13
Monday	12	16	16	13	11	15	13	10	14	12	16	14
Tuesday	13	17	17	14	12	16	14	11	15	13	17	15
Wednesday	14	18	18	15	13	17	15	12	16	14	18	16
Thursday	15	19	19	16	14	18	16	13	17	15	19	17
Friday	16	20	20	17	15	19	17	14	18	16	20	18
Saturday	17	21	21	18	16	20	18	15	19	17	21	19
Sunday	18	22	22	19	17	21	19	16	20	18	22	20
Monday	19	23	23	20	18	22	20	17	21	19	23	21
Tuesday	20	24	24	21	19	23	21	18	22	20	24	22
Wednesday	21	25	25	22	20	24	22	19	23	21	25	23
Thursday	22	26	26	23	21	25	23	20	24	22	26	24
Friday	23	27	27	24	22	26	24	21	25	23	27	25
Saturday	24	28	28	25	23	27	25	22	26	24	28	26
Sunday	25		29	26	24	28	26	23	27	25	29	27
Monday	26		30	27	25	29	27	24	28	26	30	28
Tuesday	27		31	28	26	30	28	25	29	27		29
Wednesday	28			29	27		29	26	30	28		30
Thursday	29			30	28		30	27		29		31
Friday	30				29		31	28		30		
Saturday	31				30			29		31		
Sunday					31			30				
Monday								31				

ANNEXURE 43- Checklist: Staff File

THIS IS AN EXAMPLE OF THE CHECKLIST MUST BE AFIXXED TO THE INSIDE OF THE STAFF FILE. THIS LIST IS NOT COMPREHENSIVE

THE FOLLOWING DOCUMENTATION MUST BE IN THIS STAFF FILE:

- ☐ **VACATION LEAVE RECORD**
- ☐ **SICK LEAVE RECORD**
- ☐ **ACCOUCHMENT RECORD**
- ☐ **FAMILY RESPONSIBILITY LEAVE RECORD**
- ☐ **STUDY LEAVE RECORD**

ANNEXURE 44- Performance Management Agreement

This is the National Policy and is a guideline. If the Province does not have their own policy then they can use this form.

PDS TEMPLATE- PERFORMANCE MANAGEMENT AGREEMENT

PERFORMANCE AGREEMENT PROFORMA

Following completion of this form, a copy must be forwarded to the Section:

Human Resource Management (applicable component/unit).

ENTERED INTO BY AND BETWEEN:

The Department of Local Government and Traditional Affairs herein represented by

_____ (full name) in her/his capacity

as _____ (position)

of the Department of Local Government and Traditional Affairs (herein referred to as the Employer)

and

_____ (full name) as the

_____ (position) of the

Department of Local Government and Traditional Affairs (herein referred to as the Employee)

WHEREBY IT IS AGREED AS FOLLOWS:

1. PURPOSE

1.1 The purpose of entering into this agreement is to communicate to the Employee the performance expectations of the Employer.

1.2 The performance agreement and accompanying work plan shall be used as the basis for assessing the suitability of the Employee for permanent employment (if on probation); and to assess whether the Employee has met the performance expectations applicable to his/her job. In the event that the Employee has significantly exceeded the performance expectations, he/she may qualify for appropriate rewards. Details are outlined in the Department's Performance

Management and Development System.

1.3 Should any non-agreement arise between the Employer and the Employee in respect of matters regulated by this agreement, the process outlined in paragraph 8.5 of the EPMDS should be followed. If this process fails, the employee may apply the formal grievance rules of the Public Service (published in Government Notice R1012 of 25 July 2003).

Signatures :

Employee : …….…… Date ……

Supervisor: ……Date…….…….

2. VALIDITY OF THE AGREEMENT

2.1 The agreement will be valid for the period 1 April 200_ to 31 March 200_

2.2 The content of the agreement may be revised at any time during the above-mentioned period to determine the applicability of the matters agreed upon, especially where changes are significant.

2.3 If at any time during the validity of this agreement the work environment of the Department of Local Government and Traditional Affairs change (whether as a result of Government or Management decisions or otherwise), to the extent that the contents of this agreement are no longer appropriate, the contents shall immediately be revised.

3. JOB DETAILS

Persal number :
Component :
Unit :
Salary level :
Notch :
Occupational classification :
Designation :

4. JOB PURPOSE

(Describe the purpose of the job (overall focus) as it relates to the Vision and Mission of the Department. Capture the overall accountability that the job holder has in relation to his/her position).

_____

_____

_____

_____

Signatures :

Employee : ……. Date ……

Supervisor: ……Date…….

5. REPORTING REQUIREMENTS/LINES & ASSESSMENT LINES

5.1 The Employee shall report to the _____

(job title in Department) as her/his supervisor on all parts of this agreement.

The Employee shall:

- Timeously alert the supervisor of any emerging factors that could preclude the achievement of any performance agreement undertakings, including the contingency measures that she/he proposes to take to ensure the impact of such deviation from the original agreement is minimised.
- Establish and maintain appropriate internal controls and reporting systems in order to meet performance expectations.

- Discuss and thereafter document for the record and future use any revision of targets as necessary as well as progress made towards the achievement of performance agreement measures.

5.2 In turn the supervisor shall:

- Meet to provide feedback on performance and to identify areas for development at least four times a year.
- Create an enabling environment to facilitate effective performance by the Employee.
- Facilitate access to skills development and capacity building opportunities.
- Work collaboratively to solve problems and generate solutions to common problems within the department that may be impacting on the performance of the Employee.

6. PERFORMANCE ASSESSMENT FRAMEWORK

Performance will be assessed according to the information contained in the WORKPLAN and the Generic Assessment Factors (GAFs) framework.

6.1 The KRAs and GAFs during the period of this agreement shall be as set out in the table below.

Signatures :

Employee : ……. Date ……

Supervisor: ……Date…….

6.2 The Employee undertakes to focus and to actively work towards the promotion and implementation of the KRAs within the framework of the laws and regulations governing the

Public Service. The specific duties/outputs required under each of the KRAs are outlined in the attached work plan. KRAs should include all special projects the Employee is involved in. The WORKPLAN should outline the Employee's specific responsibilities in such projects.

KRAs	Weight
Total	100%

NOTE: WEIGHTING OF KRAs MUST TOTAL 100%

6.3 The Employee's assessment will be based on her/his performance in relation to the duties/outputs outlined in the attached WORKPLAN as well as the GAFs marked here-under. At least five GAFs, inclusive of any that may become prescribed from time to time, should be selected (3) from the list that are deemed to be critical for the Employee's specific job.

GAFs	Weight
Total	100%

NOTE: WEIGHTING OF GAFs MUST TOTAL 100%

Signatures :

Employee : ……. Date ……

Supervisor: ……Date……..……

7. CONDITIONS OF PERFORMANCE

The Employer shall provide the Employee with the necessary resources and leadership to perform in terms of this agreement. Resource requirements should be outlined in the WORKPLANS of components and individual Employees

8. PERFORMANCE ASSESSMENT

The assessment of an Employee shall be based on her/his performance in relation to the KRAs and GAFs and performance indicators, as set out in this PERFORMANCE AGREEMENT and attached WORKPLAN.

The performance of the employee in respect of all individual KRAs and all individual GAFs will be assessed using a 5 point rating scale, i.e.:

5= OUTSTANDING PERFORMANCE

4= PERFORMANCE SIGNIFICANTLY ABOVE EXPECTATIONS

3= FULLY EFFECTIVE

2= PERFORMANCE NOT FULLY EFFECTIVE

1= UNACCEPTABLE PERFORMANCE

The total KRAs and the total GAF's scores are combined to produce an overall performance percentage score with percentage ranges that coincide with the above 5 point assessment scale.

Employees: KRAs shall contribute 80% and GAF's 20% of the final assessment;

.

Signatures :

Employee : ……. Date ……

Supervisor: ……Date……..……

9. FEEDBACK

Performance feedback shall be in writing on the September Review Form and Annual Review Form, based on the supervisor's assessment of the employee's member's performance in relation to the KRAs and GAFs and standards outlined in this performance agreement and taking into account the Employee's self-assessment.

10. DEVELOPMENTAL REQUIREMENTS

10.1 The Employer and Employee agree that the following are the Employee's key development needs in relation to his/her current job and envisaged career path in the Public Service. Please forward the completed PDP FORM to the Skills Development Facilitator (as it would be a requirement for the approval of training).

*ONLY ITEMISE DEVELOPMENT AREAS BELOW

…….

…….

…….

10.2 In so far as the above training needs coincide with the Employer's requirements and taking into account financial realities, the Employer undertakes to expose the Employee to development in these areas. The developmental needs of the Employee shall be reviewed as part of the September Review and the annual assessment of performance. Details of courses, conferences, etc. to be attended shall as far as possible be included in the Employee's PDP.

11. TIMETABLE AND RECORDS OF REVIEW DISCUSSIONS AND ANNUAL

ASSESSMENT

11.1 Half-yearly Review: 1st week of October

11.2 Annual Review: during April of every year.

12 MANAGEMENT OF POOR PERFORMANCE OUTCOMES

Manager and employee will identify and develop interventions together to address poor and non performance at feedback sessions, or any time during the performance cycle.

Signatures :

Employee : ……. Date ……

Supervisor: ……Date……..……

13 DISPUTE RESOLUTION

13.1 Any dispute about the nature of the employee's PA, whether it relates to key responsibilities, priorities, methods of assessment and/or salary increment in this agreement, shall be mediated by: (next person in hierarchy).

13.2 If this mediation fails, the normal grievance rules will apply.

14. AMENDMENT OF AGREEMENT

Amendments to the agreement shall be in writing and can only be effected after discussion and agreement by both parties.

Signatures :

Employee : …… Date ……Supervisor:
……Date…….

15. SIGNATURES OF PARTIES TO THE AGREEMENT

The contents of this document have been discussed and agreed with the Employee

concerned.

Name of Employee:

Signature : …… Date : ……

AND

Supervisor:

Signature :……. Date : …….

Print name …….

ANNEXURE 45- PMDS Evaluation Template

ANNUAL PERFORMANCE ASSESSMENT INSTRUMENT

THIS DOCUMENT ONLY TO BE USED FOR ANNUAL ASSESSMENT TO COVER PERFORMANCE

FOR THE ENTIRE PERFORMANCE CYCLE

The manager must forward the completed form to the Section: HR Administration for filing immediately after completion.

C O N F I D E N T I A L

Period under review 1 April 20_____ to 31 March 20_____

Surname and initials ……..

Job title ……

Remuneration level ……..

Persal no. ……..

Component ……..

Date of appointment to current remuneration level ……

Race African …... Coloured …… Indian …… White …...

Gender Male …… Female ……

Disability (Specify, if applicable) ……

(Tick the appropriate box)

Probation	Extended probation	Permanent	Contract
☐	☐	☐	☐

PART 1 – COMMENTS BY RATED EMPLOYEE

(To be completed by the Employee prior to assessment. If the space provided is insufficient, the comments can be included in an attachment)

1. During the past year my major accomplishments as they related to my performance agreement were:

_____
_____
_____
_____

Signatures :

Employee : …….. Date:…… Supervisor: ……..……Date……..…..

2. During the past year I was less successful in the following areas for the reasons stated:

_____
_____
_____
_____

PART 2 – PERFORMANCE ASSESSMENT

Standard Rating Schedule for KRAs and GAFs

Rating	Category	%	Description
1	UNACCEPTABLE PERFORMANCE	69% and below	Performance does not meet the standard expected for the job. The review/assessment indicates that the jobholder has achieved less than fully effective results against almost all of the performance criteria and indicators as specified in the Performance Agreement and Workplan.
2	PERFORMANCE NOT FULLY EFFECTIVE	70% - 99%	Performance meets some of the standards expected for the job. The review/assessment indicates that the jobholder has achieved less than fully effective results against more than half of the performance criteria and

			indicators as specified in the Performance Agreement and Workplan.
3	FULLY EFFECTIVE (and slightly above expectations)	100% - 114%	Performance fully meets the standard expected in all areas of the job. The review / assessment indicates that the jobholder has achieved as a minimum effective results against all of the performance criteria and indicators as specified in the Performance Agreement and Workplan.
4	PERFORMANCE SIGNIFICANTLY ABOVE EXPECTATIONS	115% - 129% 130% - 149%	Performance is significantly higher than the standard expected in the job. The review/assessment indicates that the jobholder has achieved better than fully effective results against more than half of the performance criteria and indicators as specified in the Performance Agreement and Workplan and fully achieved all others throughout the performance cycle.
5	OUTSTANDING PERFORMANCE	150% - 167%	Performance far exceeds the standard expected of a jobholder at this level. The review/assessment indicates that the jobholder has achieved better than fully effective results against all of the performance criteria and

			indicators as specified in the Performance Agreement and Workplan and maintained this in all areas of responsibility throughout the performance cycle.

Rating of KRAs by Supervisor and Employee:

KEY RESULT AREAS	Weight (%)	Own rating (1- 5)	Supervisor Rating (1- 5)	IRC Rating (1-5)	Dept Mod. Com. Rating (1- 5)
		Annual	Annual	Annual	Annual
1.					
2.					
3.					
4.					
5.					
Total (NOTE : Weighting of KRAs must total 100%)	100%				
Score according to calculator: Employees on level 1-12:	80%				

Signatures :

Employee : …… Date:……

Supervisor: ……Date……..

Rating of GAFs by Supervisor and Employee:

KEY RESULT AREAS	Weight (%)	Own rating (1- 5)	Supervisor Rating (1- 5)	IRC Rating (1-5)	Dept Mod. Com. Rating (1- 5)
		Annual	Annual	Annual	Annual
1.					
2.					
3.					
4.					
5.					
Total (NOTE : Weighting of GAFs must total 100%)	100%				
Score according to calculator: Employees on level 1-12:	80%				

FINAL SCORE

GRAND TOTAL	OWN RATING	SUPERVISOR'S RATING	DEPT MODERATING COM'S RATING	
KRA + GAF (80% + 20%) for levels 1-12 (As per calculator)				

PART 3 - DEVELOPMENT, TRAINING, COACHING, GUIDANCE AND EXPOSURE NEEDED

(To be completed by Supervisor in consultation with Employee)

Signatures :

Employee : …….. Date:……

Supervisor: ……Date……..

PART 4

1. Supervisor's recommendation:

---------- ---------- ----------

Signature Name Date

2. Employee's comments:

---------- ---------- ----------

Signature Name Date

3. Comments of Chairperson of Moderating Committee:

---------- ---------- ----------

Signature Name Date

4. Decision by Executing Authority or her/his delegate:

----------	----------	----------
Signature	Name	Date

Signatures :

Employee : …… Date:……

Supervisor: ……Date……..

ANNEXURE 46- Skills Audit for Staff Development

This skills audit is a tool to help you assess your essential skills as well as personal development issues. It should be seen as a baseline evaluation and help you to identify areas in which you may want to develop your skills further or grow more as a person. It is based on the McCord Hospital Competency Assessment tool as well as the National Norms and Standards for District Hospitals.

PLEASE FILL IN THE LIST AS HONESTLY AS YOU CAN

0	No knowledge or skill
1	Vague knowledge
2	Good knowledge
3	Experience but need supervision/support
4	No need for supervision
5	Can do this and have taught others

Name: _____ Date: _____

A	**CONSULTATION SKILLS**		0	1	2	3	4	5
	A1	Patient centred consultation / open ended consultation						
	A2	Continuity of care						
	A3	Coping with difficult / demanding patients and / or their families						
	A4	Note keeping using SO AP format						
	A5	Breaking bad news						
	A6	Pre- and post-HIV counselling						
	A7	Cross-cultural consultation						
	A8	Working with interpreters						

B	**PRIMARY CARE / INTERNAL MEDICINE**		0	1	2	3	4	5
		Assess and manage (acute, chronic and rehab care)						
	B1	Upper respiratory tract infections						
	B2	Pneumonia						
	B3	Asthma and COAD						
	B4	Coma- approach to investigation and management						
	B5	Diabetes- emergencies and chronic care						
	B6	Rheumatic heart disease						
	B7	Heart failure						
	B8	Hypertension						
	B9	Ischaemic heart disease						
	B10	- Acute myocardial infarction						
	B11	- Cardiac arrhythmias						
		Renal disease						
	B12	- Pyelonephritis						
	B13	- Glomerulo-nephritis and nephrotic syndrome						
	B14	- Pre-renal failure						
	B15	Diarrhoea (acute and chronic)						
	B16	Dyspepsia, including peptic ulcer disease						

	B17	Hepatitis and liver failure						
	B18	Anaemia – common types						
	B19	Bleeding disorders						
	B20	Stroke patients						
	B21	Epilepsy						
	B22	Typhoid						
	B23	Malaria						
	B24	Tuberculosis						
	B25	HIV / AIDS – holistic care						
	B26	- Opportunistic infections						
	B27	- Terminal care						
	B28	Dermatology – common skin conditions and infections						
	B29	Sexually transmitted infections						
	B30	Poisoning						
	B31	Palliative care of terminally ill patients						
	B32	Lifestyle advice / care re alcoholism/ obesity / smoking						
		Procedures						
	B33	Venopuncture						
	B34	Lumbar puncture						
	B35	Fundoscopy						
	B36	Skin biopsy						
	B37	Pleural Biopsy						
	B38	Lymph node biopsy						
		Investigations - interpretation						
	B39	ECG						
	B40	x-rays – chest						
	B41	- Abdomen						
	B42	- Barium swallow						

C	MATERNAL AND WOMEN'S HEALTH		0	1	2	3	4	5
	ANTENATAL CARE							
	C1	Organization of an antenatal service						
	C2	Obstetric risk assessment						
	C3	Obstetric ultrasound						
	C4	Management of common conditions during pregnancy e.g UTI						
	C5	Manage high risk pregnancies (hypertension, DM)						
	LABOUR							
	C6	Induction of labour / Oxytocin augmentation						
	C7	Interpretation of partogram						
	C8	Trial of labour and normal vaginal delivery						
	C9	Vaginal delivery after previous caesarean section						
	C10	Breech delivery						
	C11	Cord prolapse						
	C12	Shoulder dystocia						
	C13	Twin delivery						
	C14	Vacuum extraction						
	C15	Antepartum haemorrhage						
	C16	Pre-eclampsia / eclampsia						
	C17	**Caesarean section** – routine						
	C18	- Persistent bleeding						
	C19	- Lower segment tear						
	POST PARTUM							
	C20	Post partum haemorrhage						
	C21	Third degree tear repair (acute)						
	C22	Repair of cervical tear						
	C23	Manual removal of placenta						
	C24	Postpartum sterilization						

	C25	Postpartum depression – recognize and manage						
	C26	Family planning						
	GYNAE							
	C27	Septic abortion						
	C28	Dysfunctional uterine bleeding and menstrual problems						
	C29	Pap smear						
	C30	D&C, evacuation and manual vacuum aspiration						
	C31	Endometrial biopsy						
	C32	Termination of pregnancy - counselling						
	C33	Laparotomy for ectopic pregnancy and ovarian torsion						
	C34	Sexual assault (rape) – counseling and management						
	C35	Gynae malignancies – diagnosis and work up						

D	CHILD HEALTH		0	1	2	3	4	5
	D1	Resuscitation of neonate						
	D2	Umbilical catheterisation						
		Management of						
	D3	Premature and growth retarded babies						
	D4	Septacaemia and other severe neonatal infections						
	D5	Neonatal tetanus						
	D6	Meningitis in the neonate						
	D7	Neonatal jaundice and hepatitis.						
	D8	HIV positive infants						
	D9	Pneumonia						
	D10	Failure to thrive						
	D11	Malnutrition						
	D12	Gastroenteritis						
	D13	Childhood viral infections eg severe measles, hepatitis						
	D14	Allergy and asthma						
	D15	TB - approach						
	D16	Acute rheumatic fever.						
	D17	Meningitis						
	D18	Poisoning.						
	D19	Burn injuries to the face, hands and perineum						
	D20	Burns that involve 10% or more of the body.						
	D21	Abuse (sexual / physical)						
	D22	Sedation and pain control in children						
	D23	Use of the IMCI referral criteria						
		Procedures						
	D24	Venous access in children						
	D25	Lumbar puncture in a child						
	D26	Insertion of an intra-osseous line						

E	TRAUMA EMERGENCIES AND SURGERY		0	1	2	3	4	5
	E1	Basic Life support						
	E2	Management of shock						
	E3	Resuscitation of patients with severe trauma						
	E4	Triage skills						
	E5	Transport of the critical patient						
	E6	Debridement and suture of all types of skin lacerations						
	E7	Debridement and closure of open head injuries						

			0	1	2	3	4	5
	E8	Secondary closure of wounds						
	E9	Incision and drainage of abscesses						
	E10	Intercostal tube drainage of chest						
	E11	Surgical cricothyroidotomy						
	E12	Paracentesis						
	E13	Removal of foreign body from conjunctiva and cornea						
	E14	Removal of foreign body from ear / nose						
	E15	Severe epistaxis management						
	E16	Fine needle aspiration						
	E17	Excision of lumps including in neck						
	E18	Cautery/cryotherapy of warts and skin lesions						
	E19	Skin grafts						
	E20	Reduction of paraphimosis						
	E21	Circumcision						
	E22	Proctoscopy						
	E23	Insertion of a suprapubic catheter						
	E24	Manage peri-anal sepsis (incl Founier's gangrene)						
	E25	Torsion of the testes – surgical management						
	E26	Snake bite management						
	E27	Rabies prevention						

F	**ORTHOPAEDICS**		0	1	2	3	4	5
	F1	Conservative management of common fractures / closed reduction						
	F2	- greenstck fractures						
	F3	- supracondylar fractures						
	F4	- femur fractures in children						
	F5	- colles fracture						
	F6	Aspiration of knee						
	F7	Conservative management of joint dislocations, e.g. hip and shoulder						
	F8	Amputation – fingers, toes						
	F9	Debridement of compound fractures						
	F10	Care of spinal injury patients – acute and chronic						

G	**ANAESTHETICS**		0	1	2	3	4	5
	G1	Management of airway						
	G2	Use of local anaesthetics						
	G3	Regional anaesthetics						
	G4	> Ring block						
	G5	> Bier's block						
	G7	> Spinal Anaesthetic						
	G8	Checking anaesthetic equipment						
	G9	**General anaesthetic** - Rapid sequence induction						
	G10	- Intubation						
	G11	- Use of volatile agents						
	G12	- Ventilation of patients						
	G13	- Reversal of general anaesthesia						
	G14	Use of Ketamine						
	G15	Insertion of central lines (CVP's)						

H	**MENTAL HEALTH**		0	1	2	3	4	5
	H1	"Confused patient" - approach to management						
	H2	Stress – recognize and manage						
	H3	Depression - recognize and manage						
	H4	Suicide attempts						
	H5	Overdose - acute management (Incl. gastric lavage)						
	H6	Substance withdrawal (especially delirium tremens)						
	H7	Psychosis and schizophrenia – approach to management						
	H8	Manage psychiatric patients who are physically aggressive						

J	**COMMUNITY HEALTH**		0	1	2	3	4	5
	J1	TB management in the community						
	J2	Doing Home visits and Family assessment						
	J3	Managing visits to clinics						
	J4	Teaching skills – PHC nurses and CHWs						
	J5	Working with Community Health Workers						
	J6	Participating in Home-based care system						
	J7	Linking with community structures						
	J8	Notification of appropriate conditions						

K	**REHABILITATION**		0	1	2	3	4	5
	K1	Identify clients in need of rehabilitative / therapeutic intervention.						
	K2	Refer clients in relation to specific rehabilitation referral criteria.						
	K3	Manage /monitor pain control programmes in hospital						

L	**MEDICO-LEGAL WORK**		0	1	2	3	4	5
	L1	Certification of Death						
	L2	Sick certificates						
	L3	Disability grant applications						
	L4	Care dependency grants – developmental assessment						
	L5	J88's – assaults						
	L6	Examination of rape-victims						
	L7	Management of child abuse						
	L8	Treatment of prisoners						

M	**ADMINISTRATION / RESEARCH / OTHER**		0	1	2	3	4	5
	M1	Team work						
	M2	Drawing up doctors timetables						
	M3	Computer Literacy						
	M4	Mentoring of junior doctors						
	M5	Teaching clinical skills / use of adult educational approaches						
	M6	Facilitation / chairing of meetings						
	M7	Management of wards						

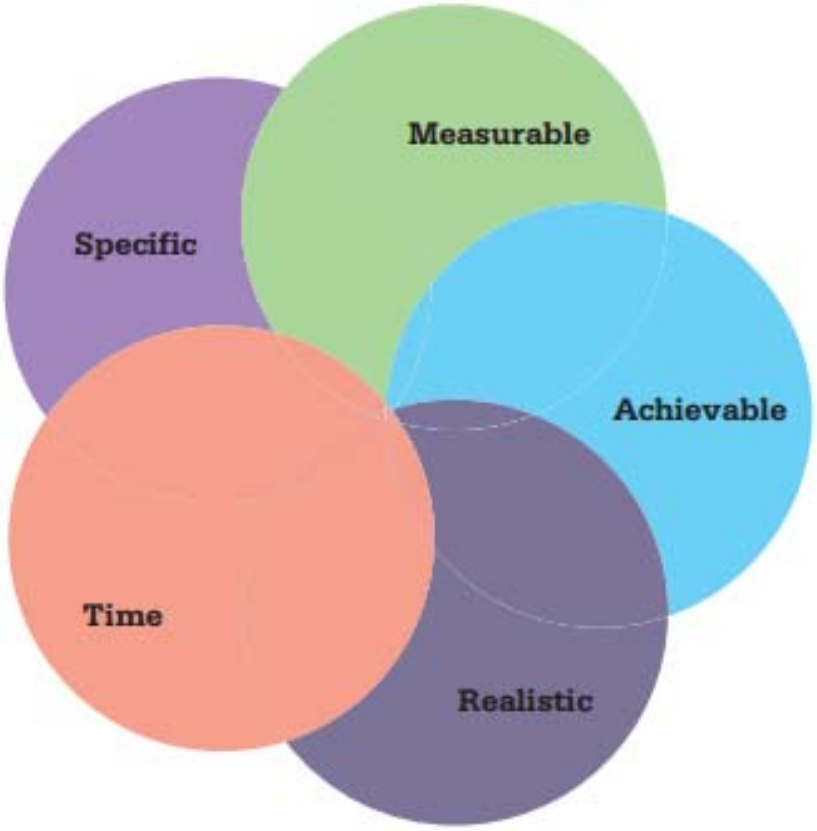
PERSONAL DEVELOPMENT

Scoring system

0 = severely problematic
1 = problematic / not going well
2 = satisfactory, but could be better
3 = doing well
4 = doing very well, no problems at all
5 = would be confident to help others who are struggling with this issue

	0	1	2	3	4	5
Ability to plan / set goals / have vision						
Motivation and positive attitude to life						
Awareness / insight into personality type - strengths & weaknesses						
Openness to feedback / advice / criticism						
Communication abilities						
Relationships with colleagues						
Seeking / giving advice to colleagues						
Friendships – close, mutually supportive friends						
Intimate relationships						
Family – closeness / cohesion / support						
Community involvement						
Spiritual awareness / development						
Managing your own stress						
Dealing with death and dying						
Time management						
Boundaries – personal vs working life						
Recreation and hobbies						
Exercise						
Diet – healthy / balanced						
Smoking						
Alcohol / drug use						
Sleep pattern						
Physical health						
Psychological health						

ANNEXURE 47- Staff Training Development Plan Goals



Specific – be precise about what you are going to achieve
Measurable – wherever possible, quantify the objective
Achievable – are you attempting too much?
Realistic – do you have the resources to make the objective happen?
Time – when will you have achieved the objective?

Critical Success Factor	Development Goal	Target Staff	Due Date	Resources and Funding	Review
All Skills listed in Audit (ANNEXURE 4.15.C)	*Training and competency in all skills*	*Nurses*	*20 January 2016*	*2 day course run by Innova Training*	*Assessments and portfolios of evidence examined and filed*

ANNEXURE 48- Acknowledgement Sheet: Disciplinary and Grievance Procedure

STAFF NAME	SIGNATURE	DATE

ANNEXURE 49- Employee Job Satisfaction Survey

Employee Health and Wellness Programme: Job Satisfaction Survey

Please take a moment and give us your answers to on this survey. Tick the appropriate box. We appreciate your taking the time to complete this questionnaire. Confidentiality is assured.

1 Biological Data

1 . What age group are you in?	18-29	30-39	40-49	50-59	60-65
2. What Nationality are you?	African	Indian	Coloured	White	Other
3. What gender are you?	Female	Male			

2. Professional Detail Data

Current work?	District office	Sub-district	Clinic		
Employment status?	Contract	Permanent	Intern	Student	Volunteer
Employment group	Support\Admin	Clinical staff	Management	SMS	
Period employed	0-5	6-10	11-20	21- above	
Highest qualification?	Matric	National dip	Undergraduate	Post graduate	Year cert

3. KEY: Strongly Disagree - 1: Disagree-2: Neutral- 3: Agree- 4: Strongly Agree-5

General	1	2	3	4	5
My job does not cause unreasonable amount of stress in my life					
I can keep reasonable balance between work and personal life					
The pace of work in this institution allows me to do a good job					

Job satisfaction					
Everybody is treated fairly in this section					
My manager \supervisor is always consistent when administering policies concerning employees					

Favoritism is not an issue					

Working conditions					
I have enough tools and equipments to perform my duties					
The necessary information systems are in place and accessible for me to get my job done					
My job is satisfactory and I enjoy my working conditions					

Communication					
Information and knowledge are shared openly within this department					
My manager\supervisor does a good job of sharing information					
Communication is encouraged in this department					

Opportunities for growth					
My work is stimulating					
I am encouraged to learn from my mistakes					
I receive the training to do my job well					
I have adequate opportunities for professional growth					

Leadership					
I can disagree with my supervisor without fear of getting in trouble					
I am comfortable sharing my opinions at work					
My ideas and opinions count at work					
I can participate in staff meetings without fear of intimidation					

G/Comments:_____
_____
_____
_____

ANNEXURE 50- Employee Health and Wellness Programme: Job Satisfaction Survey Results

EMPLOYEE HEALTH AND WELLNESS PROGRAMME: JOB SATISFACTION SURVEY RESULTS

DEPARTMENT: _____

PERIOD: _____

GENDER

MALE	
FEMALE	

POST LEVEL

LEVEL 1-6	
LEVEL 7-9	
LEVEL 10-12	
LEVEL 13+	

WORK BALANCE

	Strongly Disagree	Disagree	Neutral	Strongly Agree	Agree
My job does not cause unreasonable amount of stress in my life					
I can keep reasonable balance between work and personal life					
The pace of work in this institution allows me to do a good job					

FAIRNESS

	Strongly Disagree	Disagree	Neutral	Strongly Agree	Agree
Everybody is treated fairly in this section					
My manager/supervisor is always consistent when administering policies concerning employees					
Favouritism is not an issue					

WORKPLACE AND RESOURCES

	Strongly	Disagree	Neutral	Strongly	Agree

	Disagree			Agree	
I have enough tools and materials to do my job					
The necessary information systems are in place and accessible for me to get my job done					
My workplace is a physically comfortable place to work					

COMMUNICATION

	Strongly Disagree	Disagree	Neutral	Strongly Agree	Agree
Information and knowledge are shared openly within this department					
My manager/supervisor does a good job of sharing information					
Communication is encouraged in this department					

OPPORTUNITIES FOR GROWTH

	Strongly Disagree	Disagree	Neutral	Strongly Agree	Agree
My work is stimulating					
I am encouraged to learn from my mistakes					
I receive the training to do my job well					
I have adequate opportunities for professional growth					

PERSONAL EXPRESSION/DIVERSITY

	Strongly Disagree	Disagree	Neutral	Strongly Agree	Agree
I can disagree with my supervisor without fear of getting in trouble					
I am comfortable sharing my opinions at work					
My ideas and opinions count at work					
I can participate in staff meetings without fear of intimidation					

ANNEXURE 51- Expenditure Report (Example)

WESTRAND DISTRICT REGION - A

INSTITUTION / PROGRAME KRUGERSDORP /CENTRAL CLINIC

SUBJECT: EXPENDITURE REPORT

MAIN ITEM	COMPENSATION OF EMPLOYEES	GOODS AND SERVICES	MACHINERY & EQUIPMENTS	PROV & LOCAL GOVERNMENT	HOUSEHOLDS	TOTAL
BUDGET	R 5 301 000	R 6 491 000	R 1 251 000		R 259 000	R 13 302 000
April'15	R 345 680	R 79 427				R 425 107
May'15	R 300 845	R 1 161 304				R 1 462 149
June'15	R 399 783	R 464 126				R 863 909
July'15						R -
August'15						R -
September'15						R -
October'15						R -
November'15						R -
December'15						R -
January'16						R -
February'16						R -
March'16						R -
ACTUAL	R 1 046 308	R 1 704 857	R -	R -	R -	R 2 751 165
VARIANCE	R 4 254 692	R 4 786 143	R 1 251 000	R -	R 259 000	R 10 550 835
%SPENT	20	26	#DIV/0!	#DIV/0!	#DIV/0!	21
PROJECTIONS	R 1 395 077	R 2 273 143	R -	R -	R -	R 3 668 220

EXPECTED MONTHLY EXPENDITURE

COMPENSATION OF EMPLOYEES	R 441 750.00
GOODS AND SERVICES	R 540 917
MACHINERY & EQUIPMENTS	
TOTAL	R 982 667

CHAKING

23435739
RP015OBS

BAS
GP: HEALTH
MONTHLY EXPENDITURE REPORT
2015/04 TO 2015/06
REPORT INTRODUCTORY PAGE

DATE: 31/07/2015
TIME: 08:28:15
PAGE: 1

INSTALLATION ID	: GP: HEALTH	
LOCATION ID	: GP: HEALTH	
USERID	: 23435739	
REPORT REQUEST ID	: 00221789	
SORT CRITERIA	: R M F O S A P I	
SELECTION CRITERIA	:	
1. LAST CLOSED MONTH		: 06/2015
2. ITEM		: I
3. INFRASTRUCTURE		: S
4. OBJECTIVE		: O
5. RESPONSIBILITY		: R
6. FUND		: F
7. PROJECT		: P
8. ASSETS		: A
9. REGIONAL IDENTIFIER		: M

23435739
RP015OBS

BAS
GP: HEALTH
MONTHLY EXPENDITURE REPORT
2015/04 TO 2015/06

DATE: 31/07/2015
TIME: 08:28:15
PAGE: 2

SELECTION CRITERIA :	TYPE	DETAIL
	RESPONSIBILITY	KRUGERSDORP CLINIC-A
	REGIONAL IDENTIFIER	ALL
	FUND	ALL
	OBJECTIVE	ALL
	INFRASTRUCTURE	ALL
	ASSETS	ALL
	PROJECT	ALL
	ITEM	PAYMENTS

SORT CRITERIA	: R M F O S A P I
TOTALS	: R0008 M0007 F0008 O0010 S0005 A0008 P0005 I0003 I0010
PAGE BREAK	: NONE
PROFILE	: SECURITY
TOT ON ECON CLASS	: NO
ECONOMIC CLASS	: ALL
LAST CLOSED MONTH	: 06/2015

TYPE LEVEL	DESCRIPTION	APRIL	MAY	JUNE
R 006	KRUGERSDORP CLINIC-A			
M 004	GT: WHOLE PROVINCE			
F 004	VOTED FUNDS			
O 008	DISTRICT MANAGEMENT			

Page 1

OBAKENG

	S 005	NON INFRA/STAND ALONE: CUR			
	A 002	NON-ASSETS RELATED			
	P 002	NO PROJECTS			
	I 003	COMPENSATION OF EMPLOYEES			
	I 007	S&W: BASIC SALARY (RLS)	0.00	7.33	7.33-
		TOTAL	0.00		
TOTAL	I 003	COMPENSATION OF EMPLOYEES	0.00	7.33	7.33-
		TOTAL	0.00		
TOTAL	P 002	NO PROJECTS	0.00	7.33	7.33-
		TOTAL	0.00		

23435739
RP0150BS

BAS
GP: HEALTH
MONTHLY EXPENDITURE REPORT
2015/04 TO 2015/06

DATE: 31/07/2015
TIME: 08:28:16
PAGE: 3

	TYPE LEVEL	DESCRIPTION	APRIL	MAY	JUNE
TOTAL	A 002	NON-ASSETS RELATED	0.00	7.33	7.33-
		TOTAL	0.00		
TOTAL	S 005	NON INFRA/STAND ALONE: CUR	0.00	7.33	7.33-
		TOTAL	0.00		
TOTAL	O 008	DISTRICT MANAGEMENT	0.00	7.33	7.33-
		TOTAL	0.00		
TOTAL	F 004	VOTED FUNDS	0.00	7.33	7.33-
		TOTAL	0.00		
TOTAL	M 006	GT: WHOLE PROVINCE	0.00	7.33	7.33-
		TOTAL	0.00		
	M 006	JHB CITY OF JOHANNESBURG			
	F 004	VOTED FUNDS			
	O 008	COMMUNITY HEALTH CLINICS			
	S 005	NON INFRA/STAND ALONE: CUR			
	A 008	EQP<R5000:OFFICE FURNITURE			
	P 002	NO PROJECTS			
	I 003	GOODS AND SERVICES			
	I 008	F&O/EQP<R5000:OFFICE FURN	0.00	0.00	31,920.00-
		TOTAL	31,920.00-		
TOTAL	I 003	GOODS AND SERVICES	0.00	0.00	31,920.00-
		TOTAL	31,920.00-		
TOTAL	P 002	NO PROJECTS	0.00	0.00	31,920.00-
		TOTAL	31,920.00-		
TOTAL	A 008	EQP<R5000:OFFICE FURNITURE	0.00	0.00	31,920.00-
		TOTAL	31,920.00-		
TOTAL	S 005	NON INFRA/STAND ALONE: CUR	0.00	0.00	31,920.00-
		TOTAL	31,920.00-		
TOTAL	O 008	COMMUNITY HEALTH CLINICS	0.00	0.00	31,920.00-
		TOTAL	31,920.00-		
TOTAL	F 004	VOTED FUNDS	0.00	0.00	31,920.00-
		TOTAL	31,920.00-		
TOTAL	M 006	JHB CITY OF JOHANNESBURG	0.00	0.00	31,920.00-

Page 2

MONTHLY TRACKING FORM- EXAMPLE

BUDGET AND EXPENDITURE EXCLUDE EMS					
Financial Status per Month for the 2013/14 financial year					
WRHDR:A Finance	Original Budget R 590 494 000	adjusted amount R 51 460 000	total budget R 641 954 000		
BUDGET 2013/14					
MONTH	Expenditure for the Month	Total Exp. to date	% of budget spent to date	Variance from Budget	Projected Exp
APRIL	R 37 165 000	R 37 165 000	6%	R 553 329 000	R 445 598 000
MAY	R 37 439 000	R 74 604 000	13%	R 515 890 000	R 447 624 000
JUNE	R 54 065 000	R 128 669 000	22%	R 461 825 000	R 514 676 000
JULY	R 46 427 000	R 175 096 000	30%	R 415 398 000	R 525 288 000
AUGUST	R 38 392 000	R 213 488 000	36%	R 376 466 000	R 513 667 000
SEPTEMBER	R 45 466 000	R 258 954 000	44%	R 331 000 000	R 518 988 000
OCTOBER	R 51 274 000	R 310 228 000	53%	R 280 266 000	R 531 819 000
NOVEMBER	R 48 102 000	R 358 330 000	61%	R 232 164 000	R 537 495 000
DECEMBER	R 39 171 000	R 397 501 000	67%	R 192 993 000	R 530 001 000
JANUARY	R 38 829 000	R 436 330 000	68%	R 205 624 000	R 523 596 000
FEBRUARY	R 36 892 000	R 473 222 000	74%	R 168 732 000	R 516 242 000
MARCH	R 113 502 000	R 586 724 000	91%	R 55 230 000	

Budget and Expenditure April – March 2014 (HPDTG)

Standard Items	Budget Total	Expenditure – March 2013	Expenditure April – March 2013	% Spent	Variance	Projections
Compensation	R 17 200	R 3 663	R 19 108	111%	- R 1 908	R 17 200
Goods& Services	R 3 452	R 1 961	R 2 435	71%	R 1 017	R 3 152
Machinery & Equipment	R 748	R 0	R 0	- 0	- R 748	R 748
Households	R 0	R	R 0	0%	R 0	R 0
Non Profit	R 0	R	R 0	0%	R 0	R 0
Total	R 21 400	R 5 624	R 21 543	101%	- R 143	R 21 400

ANNEXURE 52- Acknowledgement Sheet: New Cleaner Training

STAFF NAME	SIGNATURE	DATE

ANNEXURE 53- Training Program: Cleaning

NAME	PERSAL NUMBER	TRAINING RECEIVED	DATE

ANNEXURE 54- In-service Training Record: (insert name of training)

Training conducted: (insert name of training)

Surname	Name	Persal number	Designation	Date trained	Signature

ANNEXURE 55- Checklist: Cleaning Material

Scoring: In column for Score mark as follow: present = 1; not present =0 ; Not applicable = NA

Cleaning Material	Use	Score
Chlorine compounds (bleach or Clorox)	✓ Clean up blood spills ✓ To add to Laundry water (0.01%) ✓ Surface cleaning, soaking of glassware or plastic items	
Glutaraldehydes	✓ used to disinfect medical and dental equipment.	
Sanitary all purpose cleaner	✓ For cleaning toilet bowls and other sanitary facilities e.g. Handy Andy ✓ Cleans all washable surfaces.	
Janitor trolley with Colour – coded buckets	Enables cleaning personnel to easily identify the bucket to be used in specific areas. ✓ **Red, Green, Blue and Yellow bucket**	
Colour coded cloths	✓ Red colour (for toilets, urinals and sluice) ,Green colour (for baths ,basins and showers) ,Blue colour (for furniture, doors, walls ,pictures)	
Spray bottle (containing dish washing detergent – disinfectant solution)	✓ **Dishwashing liquid**),also known as **dishwashing soap** and **dish soap**, is a detergent used to assist in dishwashing. ✓ primarily used for hand washing of glasses, plates, cutlery, and other cooking utensils in a sink or bowl	
Window cleaning squeegee	✓ A **squeegee** is a tool with a flat, smooth rubber blade, used to remove or control the flow of liquid on a flat surface such as a window pane.	
Mop sweeper or soft-platform broom	✓ General cleaning with detergent – based solutions ✓ Sweep dust off hard floors with ease and effectiveness with the dust to control sweeper.	
Water and detergent-based solutions	✓ A good all-purpose Cleaner will work on multiple surfaces and accomplish many types of cleaning needs in the home.	
Protective polymer(Stripers)	✓ It makes the floors shine and give the floor polish or sealer the required resilience and ability to withstand wear	
Total Score		
Maximum possible score (sum of all scores (10) minus the ones marked NA)		
Percentage (Total score/maximum possible sore)*100		**%**

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

ANNEXURE 56- Checklist: Restroom Cleaning (Example)

Facility Name: _____

Week Ending:_____

Area	Mon. Time			Tues. Time			Wed. Time			Thurs. Time			Fri. Time			Notes
Floor																
Basins (clean)																
Clean flowing Water																
Hand soap																
Mirrors																
Toilets (Clean)																
Toilets (Flushing)																
Sanitary Bins lids are functional																
Sanitary Bins are lined																
Toilet Paper																
Urinals																
Disposable Towels																
All bins are clean and lined																
Other																

The Facility Manager must fill in the Grey Boxes regarding times for cleaning. ***Please initial and state time next to each area listed after inspection.***

ANNEXURE 57- Schedule: Cleaning Times

Take into account busy times in the facility.

Facility Name:_____

Week Ending: _____/_____/_____

Area	Frequency	Time		
		AM	MID	PM
Administration Area	Daily			
Computer Room	Daily			
Consulting Rooms	Daily			
Corridor	Daily			
Guard Room	Daily			
Kitchen	Daily			
Meeting Rooms	Daily			
Offices	Twice Weekly			
Outside Areas	Weekly			
Reception Area	Daily			
Restrooms	Daily			
Staff rooms	Twice Weekly			
Stair ways (if necessary)	Twice Weekly			
Store Rooms	Weekly			
Waiting Rooms	Daily			

ANNEXURE 58- Checklist: Cleanliness of Service Areas

Observe the service areas using the following prompts in order to form a general impression of the cleanliness of the service areas of the facility.

Scoring: In column for Score mark as follow: when facility adhere to prompt = 1; when facility does not adhere to promt =0; not applicable = NA

Area and Prompts	**Scores**	**Scores**	**Total**
CONSULTING ROOMS:	**Score Consulting room 1**	**Score Consulting room 2**	**Total Consulting rooms**
Windows clean			
Windows not broken			
Window sills clean			
Floor is clean			
Wall skirting are free of dust			
The countertops are clean			
The door handles are clean			
Mirrors are clean			
Walls are clean			
Bins are not over flowing			
Bins are clean			
The areas are odour-free			
All areas free of cobwebs			
Total score for consultation rooms			
Maximum possible score (sum of all scores minus (NA)	**13**	**13**	**%**
Percentage for vital signs rooms (Total score/Maximum possible score)			
VITAL SIGNS ROOMS:	**Score Vital signs room 1**	**Score Vital signs room 2**	**Total Vital signs rooms**
Windows clean			
Windows not broken			
Window sills clean			
Floor is clean			
Wall skirting are free of dust			
The countertops are clean			
The door handles are clean			
Mirrors are clean			

Walls are clean			
Bins are not over flowing			
Bins are clean			
The areas are odour-free			
All areas free of cobwebs			
Total score for vital signs rooms			
Maximum possible score (sum of all scores minus (NA	**13**	**13**	
Percentage for vital signs rooms (Total score/Maximum possible score)			**%**
WAITING AREAS:	**Score Waiting area 1**	**Score Waiting area 2**	**Total Waiting areas**
Windows clean			
Windows not broken			
Window sills clean			
Floor is clean			
Wall skirting are free of dust			
The countertops are clean			
The door handles are clean			
Walls is clean			
Bins are not over flowing			
Bins are clean			
The areas are odour-free			
All areas free of cobwebs			
Total score for waiting areas			
Maximum possible score (sum of all scores minus (NA	**12**	**12**	
Percentage for vital signs rooms (Total score/Maximum possible score)			**%**
TOILETS	**Toilet 1**	**Toilet 2**	**Total Toilets**
Windows clean			
Windows not broken			
Window sills clean			
Floor is clean			
Basins clean			
Mirrors are clean			
Toilets/urinals Clean			
Sanitary Bins clean and not over flowing			
The areas are odour-free			
All areas free of cobwebs			

Total score for toilets			
Maximum possible score (sum of all scores minus (NA	**10**	**10**	
Percentage for vital signs rooms (Total score/Maximum possible score)			**%**

Summary for cleanliness of service areas

AREA	**Total Score**	**Total Maximum possible score**
Consultation rooms		
Vital signs rooms		
Waiting areas		
Toilets		
Grand total		
PERCENTAGE (Grand Total score/Grand total maximum possible score)*100		**%**

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

ANNEXURE 59- Checklist: Running water and consumables in toilets

Scoring: In column for Score mark as follow: available = 1; not available =0; Not applicable (NA)

Item	Toilet 1	Toilet 2	Toilet 3	Toilet 4	Toilet 5	Total Score
Running water						
Toilet paper						
Liquid hand wash soap						
Disposable hand paper towels						
Total score	**/4**	**/4**	**/4**	**/4**	**/4**	
Maximum possible score (sum of all scores minus the not applicable (NA) (if there is less than 5 toilets)						
Percentage ((total score/maximum possible sore)*100						**%**

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

ANNEXURE 60- Checklist: Sanitary Disposal Bin and General Bin

Scoring: In column for Total score mark as follow: present and functional = 1; not present or not functional = 0; Not applicable (NA)

SANITARY BINS

Item	Toilet 1	Toilet 2	Toilet 3	Toilet 4	Toilet 5	Total score
Sanitary disposal bins with functional lids						
Lined with appropriate colour plastic bags						
Total score	/2	/2	/2	/2	/2	
Maximum possible score (sum of all scores minus the not applicable (NA) (if there is less than 5 toilets)						
Percentage ((total score/maximum possible sore)*100						**%**

GENERAL BINS

Item	Service area 1	Service area 2	Service area 3	Service area 4	Service area 5	Total score
General disposal bins with functional lids						
Lined with appropriate colour plastic bags						
Total score	/2	/2	/2	/2	/2	
Maximum possible score (sum of all scores minus the not applicable (NA) (if there is less than 5 toilets)						
Percentage ((total score/maximum possible sore)*100						**%**

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

ANNEXURE 61- Checklist: Functional Toilets

Scoring: In column for Total score mark as follow: present and functional = 1; not present or not functional =0; Not applicable = NA

Item	Toilet 1	Toilet 2	Toilet 3	Toilet 4	Toilet 5	Total Score
The toilet bowl seat and cover/squat pan is intact and stain free						
The toilet flush/sensor flush is functional						
The toilet cistern cover is complete and in place						
The urinals are intact and functional without chokage						
The urinal/flush sensor is functional						
Total Score	**/5**	**/5**	**/5**	**/5**	**/5**	
Maximum possible score (sum of all scores minus NA scores) (if there is less than 5 toilets)						
Percentage ((Total score/maximum possible sore (25))*100						**%**

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

ANNEXURE 62- Acknowledgement Sheet: New Groundsmen Training

STAFF NAME	SIGNATURE	DATE

ANNEXURE 63- Training Program: Groundsman

NAME	PERSAL NUMBER	TRAINING RECEIVED	DATE

ANNEXURE 64- In-service Training Record: Groundsmen

Staff Member Name	Date	Start Time	End Time	Content of training

ANNEXURE 65- Checklist: Exterior Areas Cleaning and vegetation well trimmed

Observe the **general exterior environment** using the following prompts in order to form a general impression of the cleanliness of the facility.

Scoring: In column for Score mark as follow: when clean = 1; dirty =0; not applicable = NA

Prompts	Score
There is no dirt and litter around the facilities' premises	
Exterior walls of the facility are well maintained and clean	
Corridors are clean	
Total score	
Maximum possible score (sum of all scores minus the not applicable (NA))	
Percentage ((total score/maximum possible sore)*100	**%**

Observe the **general vegetation** using the following prompts in order to form a general impression of the state of the vegetation of the facility.

Scoring: In column for Score mark as follow: if facility adheres to prompt = 1; if facility does not adhere to prompt =0; not applicable = NA

Prompts	Score
Grass is cut	
Paving is free of weeds	
Flour beds are well kept and free of weeds	
Total score	
Maximum possible score (sum of all scores minus the not applicable (NA)	
Percentage ((total score/maximum possible sore)*100	**%**

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

ANNEXURE 66- SOP: Waste Management

(1) A generator of waste must not be in possession of waste that has not been classified in terms of Regulation 4 for a period of more than one-hundred-and-eighty (180) days.

(2) Waste transporters and waste managers must not accept waste that has not been classified in terms of Regulation 4.

(3) Waste must not be diluted solely to reduce the concentration of its constituents for the purposes of classification in terms of Regulation 4(1), or assessment of the waste in accordance with the Standard for Assessment of Waste for Landfill Disposal set in terms of Section 7(1) of the Act.

(4) Any container or storage impoundment holding waste must be labelled, or where labelling is not possible, records must be kept, reflecting the following-

(a) the date on which waste was first placed in the container;

(b) the date on which waste was placed in the container for the last time when the container was filled, closed, sealed or covered;

(c) the dates when, and quantities of, waste added and waste removed from containers or storage impoundments, if relevant;

(d) the specific category or categories of waste in the container or storage impoundment as identified in terms of the National Waste Information Regulations;

and

(e) the classification of the waste in terms of Regulation 4 once it has been completed.

(5) Waste generators must ensure that their waste is re-used, recycled, recovered, treated and/or disposed of within eighteen (18) months of generation.

(6) Waste managers shall not store waste for more than eighteen (18) months from generation.

(7) The re-use, recycling, recovery, treatment or disposal of waste currently stored in an existing facility must be commenced with within five (5) years from the date of commencement of these Regulations.

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ANNEXURE 67- Acknowledgement Sheet: SOP Waste Management Procedure

STAFF NAME	SIGNATURE	DATE

ANNEXURE 68- Checklist: Exterior Premises Inspection

Facility Name:_____

Date: _____

Area	Inspection	Comments
Perimeter Fence	• The quality of the fence (is it rusty, broken links etc.) • The height of the fence (no less than 1.8 meters) • The condition of the fence (any holes in the fence) • Perimeter areas shall be clear of vegetation and debris that could obscure clear observation and which could be used to breach fences	
Gates	• Separate vehicle and pedestrian gates • Gates in good working order • Gates in good condition • Locks working	
Lighting	• All lights working • Correctly positioned and spaced • Good coverage, No “dark” spots	
Equipment	• All equipment in terms of the Service Level Agreement in place	
Walls	• Painted • In good order	

ANNEXURE 69- Essential Security Resources List: Guardroom

Scoring: In column for Score mark as follow: present and functional = 1; not present or not functional =0

Item	Score
Copy of control of access to Public Premises and Vehicle Act 53: 1985	
Copy of Occupational Health and Safety Act 85: 1993	
Basic Conditions of Employment Act	
Telephone (linked to facility)	
Two way radios	
Occurrence Book	
Access Register	
Damage and deficiency log book	
Sign of Prohibited Items	
Torches	
Battery Chargers for torches and radios	
Hand-held Metal Detector	
Wall Clock	
Lockers	
Gun safe	
Key safe	
Total	**/16**
Percentage (Total/16)*100	**%**

Percentage obtained	Score
100%	Green
41-99%	Amber
<40%	Red

ANNEXURE 70- List of Prohibited Items

- Firearms.
- Knives/knife-like objects.
- Traditional weapons.
- Explosives and incendiary devices (such as ammunition, flare guns, fireworks, gas, torches, carbon dioxide cartridges, or other pressurized gas containers/tanks).
- Chemicals or disabling gas (such as mace or pepper spray), or caustic materials, including acids.
- Illegal drugs and substances.
- Alcohol,
- Syringes and needles if not part of treatment plan.
- Any mind-altering substance that potentially contributes to violent behaviour and puts staff at risk.
- Lighters or fire-starter.

Guns and Firearms

Bladed, edged or sharp objects

Club-like items and striking devices

All explosives

Incendiaries

Disabling Chemicals and other dangerous items

ANNEXURE 71- Signage: Prohibited Items

ANNEXURE 72- Essential Firefighting Equipment

Scoring: In column for Score mark as follow: present and functional = 1; not present or not functional =0

Item	Score
Fire sand buckets	
Fire extinguishers (type a, b & c fire compatible)	
Fire hoses (if a high pressure fire water hydrant is available)	
Fire hose reels	
Safe and loud fire signalling alarm	
Fire blankets	
Total	**/6**
Percentage (Total/6)*100	**%**

Percentage obtained	Score
100%	Green
41-99%	Amber
<40%	Red

ANNEXURE 73- Checklist: Fire fighting Equipment Inspection

Facility Name: _____

Date Inspected: _____

Type of Fire Fighting Equipment	Location	Date of last service	Date of next service	Condition of equipment

ANNEXURE 74- Checklist: Consulting Room Furniture

Scoring: In column for Total score mark as follow: present and functional = 1; not present or not functional =0

Item	Consultation room 1	Consultation room 2	Consultation room 3	Consultation room 4	Total score
Desk					
Chair (clinician)					
2x Chair (patient)					
2 part tilting Examination couch					
Bedside footstool - 2 steps					
Wall mounted or portable angle poise examination lamp					
Bin (general waste)					
Bin (medical waste)					
2x steel lockable Medicine cupboards					
Trolley (dressing or repurposed medicine) next to examination couch					
Wall mounted mirror above wash hand basin					
Total					**/11**
Percentage (Total/11)*100					**%**

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

ANNEXURE 75- Checklist: Essential Equipment in Consulting rooms, Vitals room and Child health room

Scoring: In column for Total score mark as follow: present and functional = 1; not present or not functional =0; Not Applicable =NA (if there are less that 4 consultation rooms)

CONSULTATION ROOMS					
Item	**Consultation room 1**	**Consultation room 2**	**Consultation room 3**	**Consultation room 4**	**Total score**
Stethoscope					
Blood glucometer					
Non invasive Baumanometer (wall mounted/ portable)					
Adult, paediatrics and large cuffs (3) for Baumanometer					
Diagnostic sets -including opthalmic pieces(wall mounted or portable)					
Patella hammer					
Handsoap dispenser(wall mounted)					
Handpaper dispenser(wall mounted)					
Penlight torch with spare batteries					
Wall mounted room thermometers					
Tape measure					
Clinical thermometers					
Total score	**/12**	**/12**	**/12**	**/12**	
Maximum possible score (sum of all scores minus the not applicable (NA)					
Percentage ((total score/maximum possible sore)*100					**%**

VITAL SIGNS ROOM					
Non invasive electronic Baumanometer (wall mounted/ portable)					
Adult, paediatrics and large cuffs (3) for Baumanometer					
Blood glucometer					
Adult clinical scale upto 150 kg					
Stethoscope					
HB meter					
Clinical thermometer					
Height measure					
Tape measure					
Bin (general waste)					
Handsoap dispenser(wall mounted)					
Handpaper dispenser(wall mounted)					
Urine specimen jars					
Total score	**/13**	**/13**	**/13**	**/13**	
Maximum possible score (sum of all scores minus the not applicable (NA)					
Percentage ((total score/maximum possible sore)*100					**%**
CHILD HEALTH ROOM					
Baby scale					
Bassinet					

Stethoscope					
Blood glucometer					
Non invasive Baumanometer (wall mounted/ portable)					
Adult, paediatrics and large cuffs (3) for Baumanometer					
Diagnostic sets - including opthalmic pieces(wall mounted or portable)					
Patella hammer					
Handsoap dispenser(wall mounted)					
Handpaper dispenser(wall mounted)					
Penlight torch with spare batteries					
Wall mounted room thermometers					
Tape measure					
Clinical thermometers					
Total score	**/14**	**/14**	**/14**	**/14**	
Maximum possible score (sum of all scores minus the not applicable (NA)					
Percentage ((total score/maximum possible sore)*100					**%**

AREA	Total Score	Total Maximum possible score
Consultation rooms		
Vital signs rooms		
Child Healt rooms		
Grand total		
Percentage (Grand Total score/Grand total maximum possible score)*100		**%**

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

ANNEXURE 76- Checklist: Resuscitation Room Monthly Inspection

Scoring: In column for Score mark as follow: present and functional = 1; not present or not functional =0

Item	Score
X-ray viewer	
Emergency trolley and accessories	
2 part delivery bed	
Oxygen cylinder and pressure gasuges	
Nebuliser	
Functional powered and manual suction devices and suction cathethers	
Drip stand	
Anaesthetic stool	
HB meter	
Dressing trolley	
Medicine trolley or lockable steel coboard	
Wall mounted lockable drug cabinet for scheduled medication	
Cardiac arrest board	
Bin (general waste)	
Kick about with bucket	
Adult semi-rigid cervical collars	
Paediatric semi-rigid cervical collars	
Head blocks,	
Spine boards	
Blankets & towel rolls	
Gloves,	
Goggles,	
Disposable aprons	
Face masks	
Resus Council Algorithms (as a poster or algorithm)	
Resuscitation documentation record	
Handsoap dispenser(wall mounted)	
Handpaper dispenser(wall mounted)	
Wall mounted room thermometers	
Total	**/29**
Percentage (Total/29)*100	**%**

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

ANNEXURE 77- Checklist: Emergency Trolley Weekly Inspection

Scoring: In column for Score mark as follow: present and functional = 1; not present or not functional =0

Item	Score
Laryngoscope set with adult blades	
Laryngoscope set with paediatric blades	
Spare bulbs for Laryngoscope	
Spare batteries for Laryngoscope	
Tracheal tubes - uncuffed (sizes 2.5 – 5.5mm)	
Tracheal tubes - cuffed (sizes 3.0 - 8.5mm)	
Ear syringe	
Penlight torch with spare batteries	
Water-soluble lubricant / lubricating jelly	
10 ml syringe	
Tape or equivalent to tie tube in place	
Tuning fork	
Patellar hammer	
Oropharyngeal airways	
Introducers for ET tubes or gum elastic bougie with adult stylets	
Introducers for ET tubes or gum elastic bougie with paediatric stylets	
Magill's forceps for adults	
Magill's forceps for paediatric	
Laryngeal masks – size 1 to 5	
Bag valve ventilation devices with oxygen reservoir & adult, paediatric & neonatal masks	
Oxygen delivery devices - partial rebreather masks, nebulizer masks, nasal prongs and T-piece	
ECG monitor defibrillator with conductive paste or pads, paddles, electrodes & razor	
Cardiac arrest board	
I.V. cannulae: 14-24G and appropriate strapping	
Syringes:1-50ml	
Needles: 14-24G	
Sharps container	
I.V administration sets	
Stethoscope	
Pulse oximeter with adult & paediatric probes	
Non invasive electronic blood pressure monitoring device including paediatric & large adult cuff sizes	
Clinical thermometer	
Blood glucose testing machine, strips and spare batteries	
Collection tubes for investigations	

Diagnostic Set and batteries including opthalmic pieces(wall mounted or portable)	
Heavy duty scissors to cut clothing	
Paediatric Broselow tape	
Consumables for wound care (Gauze, bandages, cotton wools, plasters, eye patches, alcohol swabs and antiseptic solutions)	
Suture material - May be in vicinity or another cupboard (must be accessible)	
Urinary catheters and bags	
Nasogastric tubes and bags	
Medication stickers	
Emergency medicines (also check expiry dates)	
Activated Charcoal	
Angised 0.5 mg tabs or sublingual TNT	
Adrenaline	
Amiodarone	
Antihistamine	
Aspirin	
Atropine	
Beta stimulant nebulisation (eg salbutamol) and inhaler with spacer	
Calcium chloride 10%	
Anxiolytics	
Dextrose 50% IV	
Furosemide IVI	
Glucagon	
Hydrocortisone	
Insulin – short acting	
Ipratropium nebulisation and inhaler with spacer	
Lignocaine IV vials only not ampoules	
Magnesium Sulphate 50% 1 g in 2 ml amp	
Methyldopa	
Amlodipine	
Pain management – pethidine	
Potassium chloride	
Naloxone	
Sodium bicarbonate 8.5%	
Thiamine	
Water for Injection	
IV Solutions	
Ringers lactate or equivalent balanced salt solution	
0.9% NaCl	
10% Dextrose	
Appropriate paediatric solutions (e.g. half dextrose, Darrows, neonatalyte)	

Total	**/72**
Percentage (Total/72)*100	**%**

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

ANNEXURE 78- Checklist: Sterile Emergency Delivery Pack

Scoring: In column for Score mark as follow: present and functional = 1; not present or not functional =0

Item	Quantity	Total score
Stitch scissor	1	
Episiotomy scissor	1	
Umbilical scissor	1	
Dissecting Forcep non-toothed (plain)	1	
Dissecting Forcep toothed	1	
Artery forceps straight	2	
Needle holder	1	
Small bowl	3	
Kidney dishes / Receivers (Big)	2	
EXTRAS:		
Basin	1	
Big round bowl	1	
Green towels	5	
Gown	2	
Abdominal swabs	2	
Gauzes	5	
Vaginal tampon	1	
Round cotton wools	1	
Total		**/17**
Percentage (Total/17)*100		**%**

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

ANNEXURE 79- Checklist: Equipment for Minor Surgery

Scoring: In column for Score mark as follow: present and functional = 1; not present or not functional =0

Item	Quantity	Score
MINOR STITCH / SUTURING TRAY		
Small stich tray	1	
Stitch scissor	1	
Toothed Forcep	1	
Non – toothed Forcep	1	
Blades - BP Handle size 4 or 5	5	
Mosquito straight	2	
Mosquito curved	2	
Artery forceps straight	2	
Artery forceps curved	2	
Dental syringe	1	
Needle holder	1	
Swab holder	1	
Mayo safety pin	1	
Giley Forcep	1	
Total		**/14**
Percentage (Total/14)*100		**%**

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

ANNEXURE 80- Checklist: Oxygen Supply

Facility:		Week ending:	
	Pressure Gauge Reading	Date checked	Signature
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

ANNEXURE 81- Resuscitation Protocol

Adult basic life support sequence

Basic life support consists of the following sequence of actions:

1. Make sure the victim, any bystanders, and you are safe.

2. Check the victim for a response.

- Gently shake his shoulders and ask loudly, 'Are you all right?'

3A. If he responds:

- Leave him in the position in which you find him provided there is no further danger.
- Try to find out what is wrong with him and get help if needed.
- Reassess him regularly.

3B. If he does not respond:

- Shout for help.
- Turn the victim onto his back and then open the airway using head tilt and chin lift:
    - Place your hand on his forehead and gently tilt his head back.
    - With your fingertips under the point of the victim's chin, lift the chin to open the airway.

4. Keeping the airway open, look, listen, and feel for normal breathing.

- Look for chest movement.
- Listen at the victim's mouth for breath sounds.
- Feel for air on your cheek.

In the first few minutes after cardiac arrest, a victim may be barely breathing, or taking infrequent, noisy, gasps. This is often termed agonal breathing and must not be confused with normal breathing.

Look, listen, and feel for no more than 10 s to determine if the victim is breathing normally. If you have any doubt whether breathing is normal, act as if it is not normal.

5A. If he is breathing normally:

- Turn him into the recovery position (see below).
- Summon help from the ambulance service by mobile phone. If this is not possible, send a bystander. Leave the victim only if no other way of obtaining help is possible.
- Continue to assess that breathing remains normal. If there is any doubt about the presence of normal breathing, start CPR (5B).

5B. If he is not breathing normally:

- Ask someone to call for an ambulance and bring an AED if available. If you are on your own, use your mobile phone to call for an ambulance. Leave the victim only when no other option exists for getting help.

- Start chest compression as follows:
    - Kneel by the side of the victim.
    - Place the heel of one hand in the centre of the victim's chest (which is the lower half of the victim's sternum (breastbone)).
    - Place the heel of your other hand on top of the first hand.
    - Interlock the fingers of your hands and ensure that pressure is not applied over the victim's ribs. Do not apply any pressure over the upper abdomen or the bottom end of the sternum.
    - Position yourself vertically above the victim's chest and, with your arms straight, press down on the sternum 5 - 6 cm.
    - After each compression, release all the pressure on the chest without losing contact between your hands and the sternum.
    - Repeat at a rate of 100 - 120 min-1.
    - Compression and release should take an equal amount of time.

6A. Combine chest compression with rescue breaths:

- After 30 compressions open the airway again using head tilt and chin lift.
- Pinch the soft part of the victim's nose closed, using the index finger and thumb of your hand on his forehead.
- Allow his mouth to open, but maintain chin lift.
- Take a normal breath and place your lips around his mouth, making sure that you have a good seal.
- Blow steadily into his mouth whilst watching for his chest to rise; take about one second to make his chest rise as in normal breathing; this is an effective rescue breath.
- Maintaining head tilt and chin lift, take your mouth away from the victim and watch for his chest to fall as air comes out.
- Take another normal breath and blow into the victim's mouth once more to give a total of two effective rescue breaths. The two breaths should not take more than 5 s. Then return your hands without delay to the correct position on the sternum and give a further 30 chest compressions.
- Continue with chest compressions and rescue breaths in a ratio of 30:2.
- Stop to recheck the victim only if he starts to show signs of regaining consciousness, such as coughing, opening his eyes, speaking, or moving purposefully AND starts to breathe normally; otherwise do not interrupt resuscitation.

If the initial rescue breath of each sequence does not make the chest rise as in normal breathing, then, before your next attempt:

- Check the victim's mouth and remove any visible obstruction.
- Recheck that there is adequate head tilt and chin lift.
- Do not attempt more than two breaths each time before returning to chest compressions.

If there is more than one rescuer present, another should take over CPR about every 1-2 min to prevent fatigue. Ensure the minimum of delay during the changeover of rescuers, and do not interrupt chest compressions.

6B. Compression-only CPR

- If you are not trained to, or are unwilling to give rescue breaths, give chest compressions only.
- If chest compressions only are given, these should be continuous at a rate of 100 - 120 per min.
- Stop to recheck the victim only if he starts to show signs of regaining consciousness, such as coughing, opening his eyes, speaking, or moving purposefully AND starts to breathe normally; otherwise do not interrupt resuscitation.

7. Continue resuscitation until:

- qualified help arrives and takes over,
- the victim starts to show signs of regaining consciousness, such as coughing, opening his eyes, speaking, or moving purposefully AND starts to breathe normally, OR
- you become exhausted.

ANNEXURE 82- Asset Disposal Form

Asset Disposal Form

This form is to be completed if any equipment/furniture within the facility is to be disposed of. This form, once completed, must be sent to Supply Chain Management.

Region: _____ Facility: _____

Department: _____ Date: _____

	Asset Number	Location	Description	Purchase date	Original Cost	Disposal Value
1						
2						
3						
4						
5						
6						
7						
8						

REASON FOR DISPOSAL:

_____

_____

_____

_____

METHOD OF DISPOSAL (please tick)

SCRAPPED ☐

AUCTION ☐

DONATED ☐

Authorised by: _____ Date: _____

ANNEXURE 83- Meeting Agenda: Ideal Clinic Meeting

AGENDA: _____

DATE: _____

VENUE: _____

1. Opening and welcome
2. Attendance and apologies
3. Finalisation of the agenda
4. Adoption of the previous meeting minutes
5. Matters arising from the previous meeting's minutes
6. Standing items
7. Additional matters
8. Date of next meeting
9. Closure

ANNEXURE 84- Attendance Register: Ideal Clinic Meeting

Ideal Clinic Meeting

Date: _____ District: _____

Name & Surname	Rank	Contact Number	Organisation / Section	Signature

ANNEXURE 85- Minutes of the Meeting (template): Ideal Clinic Meeting

AGENDA: PRIMARY HEALTH CARE PROGRAMME MEETING

DATE: _____

VENUE: _____

TIME	ITEM	RESPONSIBLE PERSON
	Opening and welcome	
	Attendance and apologies	
	Finalisation of the agenda	
	Adoption of the previous meeting minutes	
	Matters arising from the previous meeting's minutes	
	Standing items	
	Additional matters	
	Date of next meeting	
	Closure	

ANNEXURE 86- Clinic Open Day: Suggested Activities

Theme: Immunization/ Child Health

Before the event: Use health promoters to inform community about the event. Request community members to bring RTHC.

MC:	Facility manager: Purpose of Open Day
Welcome speech:	Local ward counsellor
Opening Speech:	MCWH coordinator: The importance of Immunization
MC:	Explain the activities offered
Activities:	Check RTHC Offer catch-up immunization Screening height and weight Screening developmental milestones
Stations:	1. Screening 2. Immunization 3. Facts and information about Immunization/ Child Health (with pamphlets) 4. Children's activities (colouring, face-painting, clowns, magicians)

ANNEXURE 87- Register: Ambulance Turnaround Times

REQUEST DATE	REQUEST TIME	REQUEST CLINICIAN	CLINICIAN SIGNATURE	PATIENT NAME	PATIENT NUMBER	ARRIVAL DATE	ARRIVAL TIME	NAME RESPONDING OFFICER	SIGNATURE RESPONDING OFFICER	ACTUAL TURNAROUND TIME

ANNEXURE 88- Referral Pathways

The referral pattern in the district involves:

1. Vertical referral

- Vertical referral, i.e. patient referral from a lower to a higher level of healthcare facility, either in the same district or another district, and vice versa, based on the role and responsibilities of each category of healthcare facility.
- School Health Teams and the Nurse Team Leader of the ward-based PHC Outreach Teams refer all cases that cannot be managed at PHC level, emergency cases included, directly to the Level 1 hospital in the catchment area.
- PHC clinics refer all cases that cannot be managed at PHC level to the Level 1 hospital in the catchment area, according to clinical guidelines.
- Oral health outreach services refer cases for advanced oral health services to the fixed clinics. Severe maxilla-facial and orthodontic cases are referred to Pelonomi Tertiary Hospital.
- Level 1 hospitals refer patients in need of specialist health care to the Level 2 hospital in the catchment area.
- When there is a justifiable reason for deviation from the standard referral pattern, a Level 1 hospital may bypass the standard route of referral and send the patient directly to the Level 3 hospital. The Head of Clinical Services of the Level 2 Hospital must give clearance for a Level 1 hospital to bypass the standard referral route and send a patient directly to the Level 3 hospital.
- Level 2 hospitals refer patients in need of specialist health care to the appropriate tertiary facility.

All referred patients at all levels are to be referred back from the referral facility to the referring facility.

2 Horizontal Referral

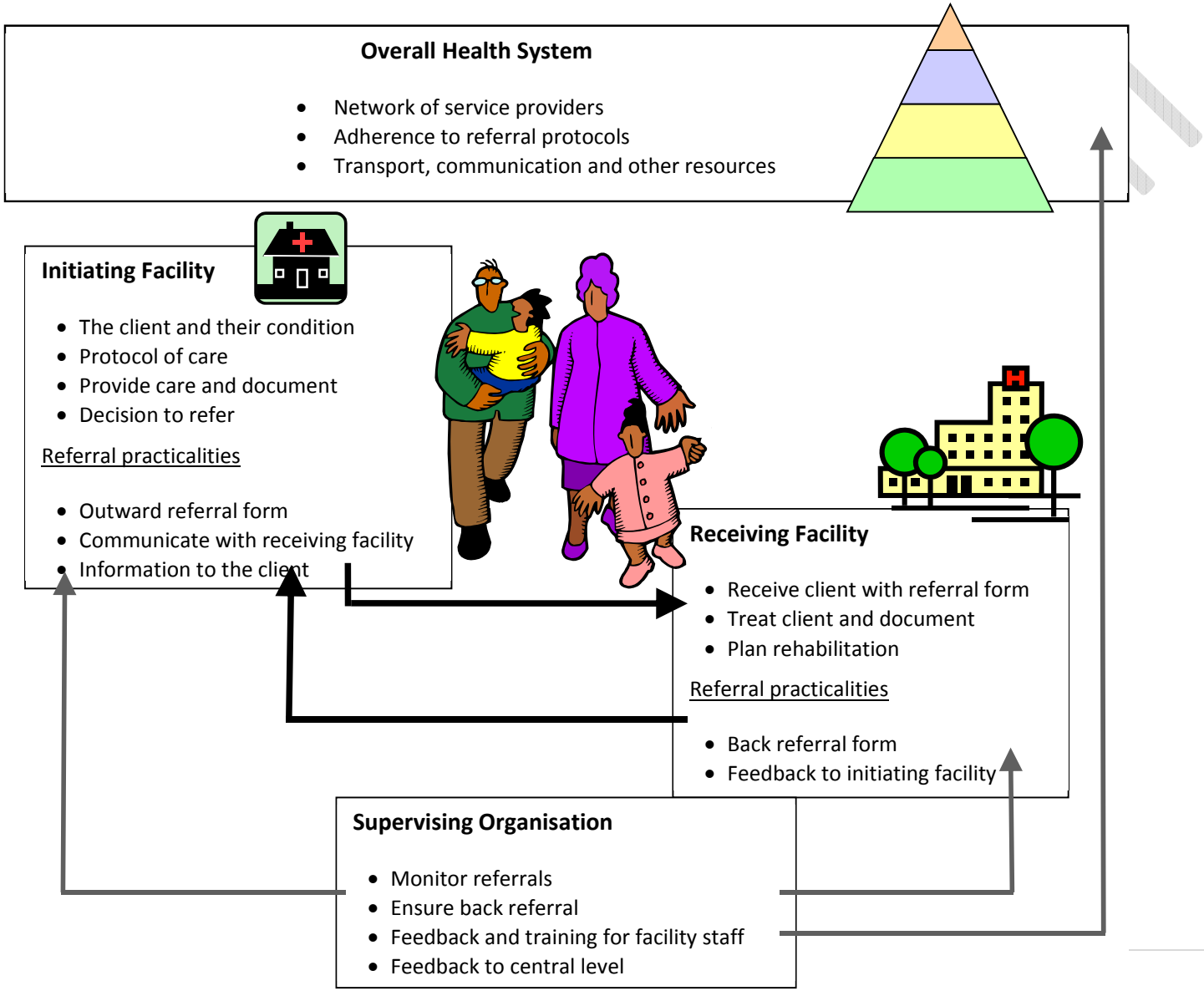
- Horizontal referral, i.e. patient referral to a healthcare setting with similar scope and healthcare service package, for continuity of care, either in the same district or another district.
- Patients are referred between hospitals of similar level, e.g. a patient admitted to a hospital far from his residence may be referred to a hospital closer to where he resides.
- School Health services refer all school-going children in need of medical and dental health care to a PHC facility in the catchment area.
- The Community Healthcare Workers (CHW) in the Ward-based PHC Outreach Teams refer patients requiring medical or dental health care to the PHC clinic in the catchment area for assessment and further management.
- Patients are referred from one PHC facility to another, e.g. referral of a patient who receives monthly medication for a chronic condition at a PHC facility, who relocates to another area in the same sub-district or another sub-district within the district or another district.

- A patient can be referred from one ward-based PHC setting to another, e.g. a patient on ARVs who relocates from one ward to another within the District can be referred by the Ward-based PHC Outreach Team leader to the care of the Ward-based PHC Outreach Team operating in the ward into which the patient will be relocating.

3 Downward Referral

- Patients who entered a certain level of care without referral, who require a lower level of care after initial assessment, or who are in need of continuity of care, follow-up and rehabilitation are down-referred to the appropriate level of care.
- 8.1.3.2 Patients are referred from a PHC facility to the ward-based CHW for services rendered at their level, e.g. a TB patient on clinic-based DOTS can be referred to community-based DOTS by the CHW under the supervision of the Nurse team leader.
- Referrals to and from other organisations and government departments
- Patients are also referred to other organisations and government departments which render services that are beyond the scope of the District healthcare service. These entities refer clients in need of healthcare to PHC facilities where they will be managed accordingly, e. g. Department of Social Development may refer a baby, who has not been immunised and whom they have detected during their course of work, to the PHC facility in the catchment area for immunisation.
- Referrals from private healthcare practitioners

Private healthcare practitioners refer patients who require healthcare services at PHC level or a higher level of healthcare, and who are not financially capable to pay for private healthcare services, to a public healthcare facility where they will be treated according to public health policies.


Overall Health System
Network of service providers
Adherence to referral protocols
Transport, communication and other resources
Initiating Facility
The client and their condition
Protocol of care
Provide care and document
Decision to refer
Referral practicalities
Outward referral form
Communicate with receiving facility
Information to the client
Receiving Facility
Receive client with referral form
Treat client and document
Plan rehabilitation
Referral practicalities
Back referral form
Feedback to initiating facility
Supervising Organisation
Monitor referrals
Ensure back referral
Feedback and training for facility staff
Feedback to central level

ANNEXURE 89- List of Referral Services

Available Services	Contact Numbers
The CHC, hospital or other public health services that you refer to routinely	
Private hospitals and clinics in the area	
Prison clinics and workplace occupational health clinics	
Private practitioners (doctors, specialists, physiotherapists, occupational therapists)	
Ambulance services	
Dental facilities and other specialist health services	
Traditional healers	
Psychosocial and community support services (public and private)	
Social workers, psychologists, counsellors and other social support services such as SASSA	
Influential community leaders and religious institutions that provide community support	
NGOs providing HIV support groups, home-based care, orphan and vulnerable child care	
Organisations providing food and shelter aid	
Organisations providing legal aid including support for gender-related issues	
Public services available to residents	
Police services	

Fire department	
WBPHCOTs services	
Recreational facilities such as sports or community centres, youth groups, church groups, libraries.	

ANNEXURE 90- Register: Patient Referral

Name of Facility _____		Facility Manager _____		Contact no. _____
Date:	**Patient Details:**	**Referral Destination:**	**Reason:**	**Feedback from Referral Destination**

ANNEXURE 91- Reporting Template

NAME OF ORGANISATION: _____

PERSON REPORTING: _____

DATE OF MEETING: _____

Objective 1:			
Activity	**Progress**	**Challenges**	**Mitigation Actions**

Planned activities for next quarter

_____

_____

_____

THANK YOU FOR THE SUPPORT!

ANNEXURE 92- Staff Orientation: Policies and MOUs

I have read and understand the following MOU:

Name of MOU: _____

Date received: _____

Presented by: _____

Name	Job designation	Signature

Facility manager name: _____

Facility manager signature: _____

Date: _____