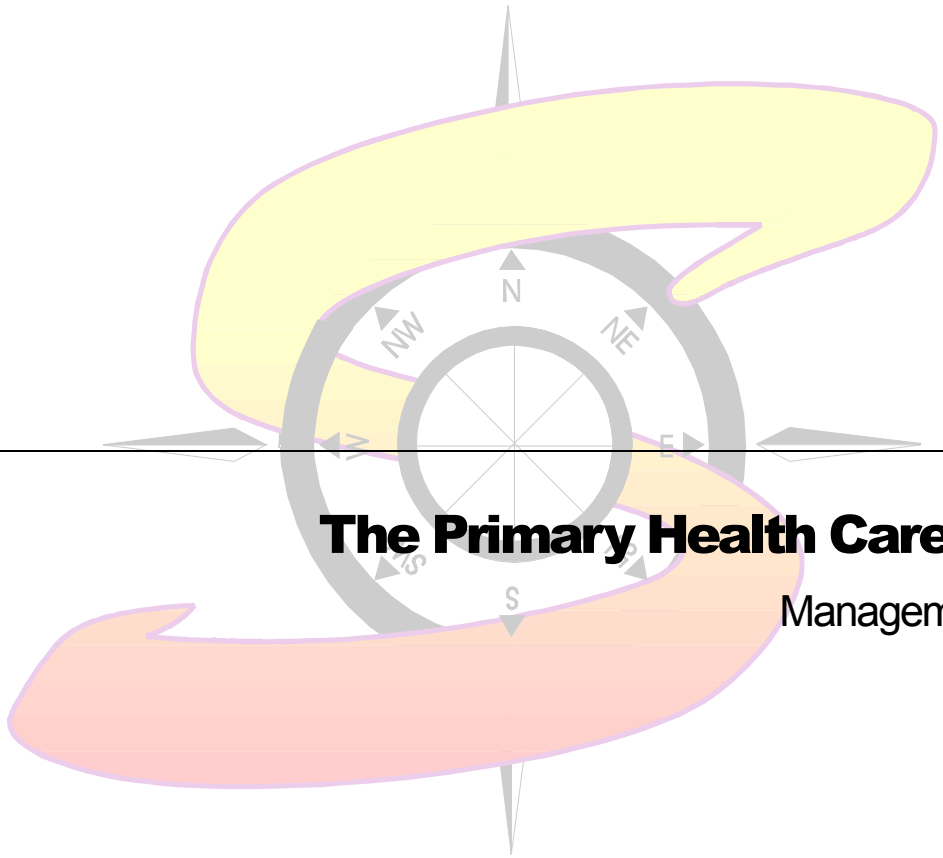

The Primary Health Care Program

Management Guideline

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1 INTRODUCTION

1.1 State provided health care services in the South Africa are overstretched. The overcrowding of these facilities also means that there are often long delays for workers in receiving attention which, in turn, means more time lost from work even for consultations for minor ailments.

1.2 The costs of private health care are also constantly increasing and are largely beyond the reach of those who are not covered by medical aid. It is because of the high direct costs to the workers, and indirectly to the company through lost time, and indirectly to the company through lost time, that the company provides care for certain acute and chronic disorders.

1.3 Many of these diseases need on-going assessment and continued treatment and the OHS will be in the best position to treat them because workers will have regular and easy access to the clinic which makes compliance with the treatment easier to maintain. Treatment by the OHS also ensures that the OHS staff are aware of the worker's health problem and are able to advise on any limitations or adaptations that are necessary for his/her work.

2 SCOPE

2.1 The Primary Healthcare Programme will be made available exclusively to the employees of the Company.

2.2 The medications kept in the dispensary will be limited to those prescribed by the Medicines and Related Substances Act (101 of 1965).

2.3 Employees who are on medical aid will be offered minimal quantities of medication from the clinic dispensary – they will be issued a prescription, and expected to purchase their medications through their medical aid fund.

3 APPROACH TO IMPLEMENTATION: OVERVIEW

The implementation of the Primary Health Care programme comprises two phases:

- Set-up Phase
- Operational Phase

The set-up phase is described in the Guideline for setting up the OH Service.

4 APPROACH TO IMPLEMENTATION: PROGRAM OPERATION

The steps involved in operationalising the programme are as follows:

4.1 Daily patient visits

Employee visits generally comprise the following reasons:

- Injury or illness treatment
- Chronic condition monitoring
- Reproductive health visits (family planning)

These encounters will include a certain amount of health education.

The typical "workflow" for these visits includes the following:

Patient arrives (scheduled or not).

- Patient is entered into daily visit register.
- Patient folder is retrieved from the records.
- If there is a separately staffed reception area, the patient is deployed to an ON Nurse by the receptionist.

The Nurse or Doctor encounter.

- The patient is treated with dignity & respect, even though they can be difficult!
- Detailed notes are kept. This is an extremely important part of the professional's responsibility. They should follow the elements of the "Problem-Oriented Patient Record", with the following featured:
  - **S**: Subjective presentation of the problem
  - **O**: Objective description of the professional's findings.
  - **A**: Assessment of the problem, in the view of the treating professional (including a differential diagnosis).
  - **P**: Plan, including treatment plan as well as patient education.

The prescription and issue of medicines.

This phase is regulated by law, and should be considered accordingly. The "***general rule regarding the responsibilities of health professionals with regard to allopathic medicines***" is as follows;

- Every prescription requires a diagnosis, which is recorded in the notes. In this setting, a "diagnosis" has a legal implication, and can only be performed by a medical practitioner or a nurse under the authorisation of the responsible medical practitioner (section 38A of the nursing act).

- Once the diagnosis has been made, the prescription is given, with due care of side effects, drug interactions, etc.
- The next step in the chain is dispensing of the prescribed medicines. In the occupational health setting, the prescription can only be dispensed by the prescriber, and only by a professional with a dispensing licence.
- The next step is the administration of the medicines. This is by various routes, such as intravenous, intramuscular, inhaled, percutaneous, oral and others (rectal, vaginal, etc.). This can be performed by the patient himself/herself, or by the dispenser.
- The final phase is the evaluation of the outcome, which could be any time after the administration; minutes to days to weeks.

Once the encounter is over, consideration is given to:

- Patient deployment (is he/she fit to return to work?). If sick leave is required, the appropriate certificate is to be completed, and issued. The appropriate supervisor is to be informed.
- A review (return) date

The patient record is captured in the clinic IT system, including the stock management component.

4.2 Emergency Preparedness

A critically important aspect of the routine activities in the clinic is to monitor the emergency equipment, and ensure that it is functional, placed correctly, and that consumables (medicines) have not expired.

A checklist of emergency medicines is listed in the SOP “Emergency Preparedness for a Clinic”.

4.3 Medicines Control

The Medicines Act places considerable responsibility on the healthcare professionals in the clinic to control the manner in which medicines are acquired, stored, issued, tracked, recalled if necessary, disposed of, and documented. These are all detailed in operating procedures, including:

- Cold Chain Management
- Disposal of obsolete stock
- Management of new stock
- Management of product recalls
- Pest Control
- Procurement of Medicine Supplies

- Returned Goods
- Stock Maintenance
- Waste Management-Onsite Clinic

4.4 Data analysis and Management Reporting

Typical data management requirements to consider include:

- Daily encounter management: scheduling & diary functions, recording visits and key outcomes
- Medicines management & stock control

Typical reporting requirements to consider include:

- Utilisation (average daily visits by department or job category)
- Medical categories (minor illnesses, chronic disorders, family planning, EAP, occupational illnesses & injuries)
- Diagnoses (grouped by organ system or types of common disorders)
- Disposal of Patients (referral routes & reasons; sick leave allocated)
- Service Costs (per head per month; per head per encounter)

4.5 Quality Control

The Occupational Health Care program must be subject to a process of ongoing evaluation and audit. This involves a systematic approach to legal compliance & peer review, in order to identify gaps and provide mechanisms for improvement.

OH staff members should make extensive use of checklists in the course of their daily activities, to that all potential gaps are covered.

Those responsible for quality control should regularly inspect these checklists, to unsure they are being used (correctly).

Calibration of equipment is essential for good quality control. The most important of these in the Primary Health Care setting are the sphygmomanometer, spirometry equipment, scale (patient weight), and blood testing devices, such as the glucometer. The calibration steps & frequencies are prescribed in the relevant procedures, or are provided with the equipment.

5 RESPONSIBILITIES

The roles and responsibilities of the Occupational Health Nurse, Primary Health Care Nurse, and Occupational Medicine Practitioner are described in the document “Guideline – OH Roles and Responsibilities”.

NB: The responsibilities of the medical practitioner to legitimately authorise the nurse to act on his/her behalf, as issued by the Department of Health, are listed in the appendix.

6 APPENDICES

Appendix 1: Legislation to be considered for the Primary Health Care Program

Appendix 2: Guidelines for the issue of a section 38A authorisation to a nurse (as prescribed by the Department of Health)

Appendix 3: The Section 38A Authorisation form

Appendix 4: Extract from the Nursing Act (Section 38A), as amended in 1981.

6.1 Appendix 1: Legislation to be considered for the Primary Health Care Program

- The Medicines and Related Substances Control Act No 101 of 1965 as amended, and General Regulations (2003).
- The Nursing Act No 50 of 1978
- The Nursing Amendment Act No 71 of 1981 (section 38A).
- The Nursing Act 33 of 2005 (partially enforced).
- The Health Professions Act 56 of 1974, and Regulations
- The Ethical Rules Of Conduct For Practitioners Registered Under The Health Professions Act, 1974 (4 August 2006)
- The National Health Act No 61 of 2003 and Regulations as amended.
- The Medical Dental and Supplementary Health Service Profession Act No 56 of 1974
- The Basic Conditions of Employment Act No 3 of 1983 as amended – Act 75 of 1997

Important: The legal background to nurses, permits and licenses is discussed in the sections and appendices of the Guideline on setting up an Organisational Health Service.

6.2 Appendix 2: Guidelines for the issue of a section 38A authorisation to a nurse (as prescribed by the Department of Health)

Introduction

The permit to purchase, keep and dispense medication under section 22a of Act 101 does not make provision for the nurse to assess, diagnose, treat and prescribe for ailments encountered in a primary care context. Section 38A of the Nursing Act (50 of 1978) makes provision for nurses working in designated health care facilities to be authorised to assess, diagnose, prescribe and treat certain health conditions if a medical practitioner or pharmacist is not available. However, until recently, clinics in the private sector were not designated, and occupational health nurses were practising illegally. As an interim measure, recognising the crucial role that occupational health clinics play in the provision of primary and emergency care to employees who cannot afford medical aid, the Director-General: Department of Health has designated occupational health clinics under section 38a of the Nursing Act (50 of 1978). This interim concession allows the doctor in charge of the clinic to authorise the nurse to diagnose, prescribe medication and treat patients presenting to the clinic when the doctor is unavailable. This guideline sets out criteria to assist the medical practitioner in giving this authority.

- The doctor must be familiar with the terms and conditions of the permit issued to the clinic under section 22A of The Medicines and Related Substances Control Act (101 of 1965).
- The doctor should assure himself/ herself that the nurse is competent to perform the tasks being authorised by the permit. This should be through appropriate training, qualification, by evaluation of past experience and by work under direct supervision for a period. A qualification does not necessarily guarantee competence.
- The nurse should not be asked to perform any task that is beyond his/her scope of practice or that he/ she is not competent to perform.
- There should be a comprehensive set of treatment protocols relating to the management of all medical conditions likely to be encountered in the clinic. Suitable algorithms should be built into the protocols. There should be clear instructions on when to refer, what treatment the nurse can initiate, what treatment can be changed and the circumstances under which changes can occur. All such changes should be recorded in the patient's file and countersigned at the earliest opportunity (not greater than one week as the case may be). The management of emergencies should be specifically addressed by these protocols and it is advisable that all nurses working in these clinics should have completed appropriate training (including regular refresher courses) in the management of common emergency situations.
- The treatment protocols should be supported by standing orders pertaining to the running of the clinic. These standing orders should list the conditions that the nurse is allowed to treat and should be reviewed and updated annually.
- There should be open channels of communication between the doctor and nurse at all times and the doctor should be available for consultation during the hours that the occupational health clinic is open.

- The doctor should be present in the clinic for the recommended number of hours according to the table below.
- A formal drug control system should be implemented. Each prescription for schedule 3 or 4 drugs should be checked against the case notes and the drugs register and signed off in the drug register by the doctor.
- Stock checks should be taken monthly and balanced against the drug register, signed by the nurse and countersigned by the doctor.
- No charge may be levied for medicines dispensed to employees under this permit.

It should always be remembered that the doctor remains the person ultimately responsible and accountable for the treatment of patients attending the clinic. As with doctors, nurses should be careful not to practise beyond their scope of practice and are responsible for their own act and omissions. They should not be coerced to practise beyond their competence. Doctors should ensure that only medicines on the prescribed list (as issued by the Department of Health) are ordered and stocked by the clinic, unless written permission has been obtained to order additional medicines not on the list.

Number of Employees at site	Hours Dr should be present in the clinic per week
1 – 500	1
501 – 1000	2
1001 - 1500	3
1501 – 2000	4
2000 - 3000	5
3000+	Full time doctor

These are minimum guidelines and additional time may be necessary depending upon the risk profile of the industry.

Appendix 3: The Section 56(6) Authorisation form

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

AUTHORITY UNDER SECTION 56(6) OF THE NURSING ACT, 2005 (ACT 33 OF 2005)

Name of Nurse: ……

Clinic: ……

You are hereby authorised to diagnose prescribe and dispense medicines for the conditions listed in the standing orders of the clinic according to the treatment protocols listed in the standing orders of the clinic according to the treatment protocols listed below subject to the limitations imposed by the Regulations to Section 56(6) of the Nursing Act.

You are to maintain legible, comprehensive clinical notes in the patient file and to complete the drug register required under the licence issued in terms of section 22C (1) (a) of the Medicines and Related Substances Act (Act 101 of 1965) as amended.

Name of Medical Practitioner in charge: ……

Signed at …….. **on** …… **day of** …… **20**……..

Signature: …….. **Qualifications:** ……..

HPCSA No: ……

Address: ……

……

……

Tel: (……**)** ……..

PROTOCOLS:	Mark Relevant protocols
STI	
Primary Health Care	
EPI (Extended Program for Immunisation)	
T B	
Diabetes	
Hypertension	
Travel Medicines	

Appendix 4: Extract from the new Nursing Act (Act 33 of 2005) (Section 56(6))

56(6) Special provisions relating to certain nurses

(6) Despite the provisions of this Act, the said Medicines and Related Substances Act, 1965, the Pharmacy Act, 1974 (Act No. 53 of 1974), and the Health Professions Act, 1974 (Act No. 56 of 1974), a nurse who is in the service of -

(a) the national department;

(b) a provincial department of health;

(c) a municipality; or

(d) **an organisation performing any health service designated by the Director-General** after consultation with the South African Pharmacy Council referred to in section 2 of the Pharmacy Act, 1974,

and who has been authorised by the Director-General, the head of such provincial department of health, the medical officer of health of such municipality or **the medical practitioner in charge of such organisation**, as the case may be, may in the course of such service perform with reference to -

(i) the physical examination of any person;

(ii) the diagnosing of any physical defect, illness or deficiency in any person; or

(iii) the keeping of prescribed medicines and their supply, administering or prescribing on the prescribed conditions;

any act which the said Director-General, head of provincial department of health, medical officer of health or **medical practitioner**, as the case may be, may, **after consultation with the Council**, determine in general or in a particular case or in cases of a particular nature, **if the services of a medical practitioner or pharmacist, as the circumstances may require, are not available**.

Appendix 5: Extract from the **old** Nursing Act (Section 38A)

38A Special provisions relating to certain nurses

Notwithstanding the other provisions of this Act and the provisions of the Medicines and Related Substances Control Act, 1965 (Act 101 of 1965), of the Pharmacy Act, 1974 (Act 53 of 1974), and of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974), **any registered nurse** who is in the service of the Department of Health, Welfare and Pensions, a provincial administration, a local authority or **an organization performing any health service and designated by the Director-General**: Health, Welfare and Pensions after consultation with the South African Pharmacy Board referred to in section 2 of the Pharmacy Act, 1974, and who has been authorized thereto by the said Director-General, the Director of Hospital Services of such provincial administration, the medical officer of health of such local authority or **the medical practitioner in charge of such organization,** as the case may be, may in the course of such service perform with reference to-

(a) the physical examination of any person;

(b) the diagnosing of any physical defect, illness or deficiency in any person;

(c) the keeping of prescribed medicines and the supply, administering or prescribing thereof on the prescribed conditions; or

(d) the promotion of family planning,

any act which the said Director-General, Director of Hospital Services, medical officer of health or medical practitioner, as the case may be, may **after consultation with the council** determine in general or in a particular case or in cases of a particular nature: **Provided that such nurse may perform such act only whenever the services of a medical practitioner or pharmacist, as the circumstances may require, are not available**.

[S. 38A inserted by s. 2 of Act 71 of 1981.]