National Referral Policy

LONG GOD YUMI STANAP

MINISTTRY OF HEALTH

ACKNOWLEDGMENT

This referral policy reflects an extensive consultation process with stakeholders, both within and outside of the Ministry of Health (MOH). Within the MOH, this included senior executives, the National Policy Advisory Group, program managers, provincial corporate and public health managers, community health staff, hospital clinicians, nursing staff, allied health staff, and corporate representatives. Beyond the MOH, it involved Development Partners, Non-Governmental Organizations and Private Health Providers.

The principles and guidance outlined in the referral policy are based on a combination of international best practice and ideas of all the people and organizations that have contributed to the development. The National Policy Advisory Group and the MOH would therefore like to express their gratitude and appreciation to all.

Specific acknowledgement is extended to the Government of Australia for provision of technical advisory support. In particular, we would like to recognize the Vanuatu Health Resource Mechanism (VHRM) and Brett Cowling (Policy Advisor Consultant, VHRM) that were instrumental in the development of the Referral Policy.

FOREWORD

As the Ministry of Health, I am pleased to present the National Referral Policy for health care services in Vanuatu. Seeking to create a healthy population that enjoys a high quality of physical, mental, spiritual and social well-being is at the heart of government policies and although we have been striving to improve our health services, much more remains to be done in the years ahead. This policy is designed to assist the planning and coordination of patient care between the different levels of health care services, beginning from the Aid Posts to rural Primary Health Care facilities and cascading up to the secondary and tertiary level of care provided by the four provincial hospitals and the two main referral hospitals.

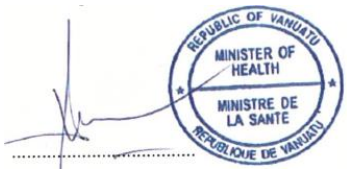
The current referral system is inconsistently applied due to lack of referral criteria and guidelines. As a result, numerous patient lives are at risk while some lost, during travel from an initiating facility to the upper level of care. In addition, the referral system has led to an overcrowding of referral hospitals that end up handling patients who could otherwise be managed at lower levels of health care, thereby imposing a significant financial burden on the health care system.

This National Referral Policy aims to address the current gaps resulting from the absence of a referral policy in the Ministry of Health. The policy should positively affect accessibility to health care services and is supplementary to the role delineation policy which aims to properly resource health facilities in terms of staffing and infrastructure (instrument and equipment) to meet standards that will then clearly define the level of care for each health facility.

The policy provides clear roles and responsibilities of health care workers for different levels of care in health facilities, depending on patient need for care and treatment based on evidence. The policy is designed to assist health services to manage patient referrals and to support appropriate, informed and timely access to clinical care. It is about making timely referrals based on clinical assessment, communication between different levels of care, approval to transfer, and supporting a patient's acute and ongoing care management, discharge and follow-up care.

Our partners and stakeholders play a key role in supporting us to deliver, therefore this policy also allows for collective planning through joint mechanisms and collaborative approaches of our interventions with our key stakeholders both on-going and yet to be established.

I take this opportunity to thank all internal and external stakeholders especially our donor partners for their willingness and continued support to help us deliver the health service that meets people's needs. We are determined that our whole population will have access to equitable and affordable quality health care.



Honorable Norris Jack Kalmet (MP)
Minister for Health

ABBREVIATIONS	
MoH	Vanuatu Ministry of Health
PHC	Primary Health Care
PH	Public Health
WHO	World Health Organization
SBAR	Referral Form outlining Situation, Background, Assessment and Recommendations
CQI	Continuous Quality Improvement
RDP	Role Delineation Policy
SGBV	Survivor of Gender Based Violence
ED	Emergency Department
O&G	Obstetrics and Gynecology
OIC	Officer in Charge
STI	Sexually Transmitted Infection
Triage	Triage
HR	Heart Rate
RR	Respiratory rate
SpO2	Oxygen Saturation measured as %
AVPU	Alert Voice Pain Unresponsive
BSL	Blood Sugar Level
MO	Medical Officer
NO	Nursing Officer
NDMO	National Disaster Management Office

CONTENTS

FIGURES

TABLES

Policy Name:	NATIONAL REFERRAL POLICY				
Approval Authority:	Director General	**Adopted:**	December 2019	**Reviewed:**	
Responsible Office:	Hospital and Curative Services	**Contact:**	jwabaiat@vanuatu.gov.vu		

POLICY SCOPE

This Policy applies to all health service providers and health service delivery partners who provide patient care and initiate approved patient referrals (urgent or non-urgent), plus those who receive patients from initiating health facilities, and who discharge patients back to rural health facilities, urban clinics or home. This policy provides a clear direction to effectively and efficiently manage the patient referral system within Vanuatu and internationally from Vanuatu. In addition, it provides guidance for clinicians on patient transfer and triage.

The development of this policy seeks to address shortcomings resulting from the absence of a referral policy in the Ministry of Health. Inconsistent and inappropriate referral has negatively affected accessibility in health care provision. This document outlines the following main aspects related to the referral of patients; referral criteria; communication between different levels of health care delivery to facilitate the referral; transportation of referred patients; and equitable distribution of resources to improve the management of referrals.

POLICY STATEMENT

The National Referral Policy is designed to assist the planning and coordination of patient care between the different levels of health care services – Aid Posts, Rural Primary Health Care Facilities (Dispensaries and Health Centers) and Provincial and National Hospitals.

All decisions to refer a patient from one level of care to the next appropriate level of care are based upon a clinical assessment of a patient's need for care/treatment. Implementing the Patient Referral Policy promotes a professional and ethical approach to patient management, cost effective use of scarce health service resources and strengthens the lines of communication between clinicians at each level of care.

This Policy is an integral component of the 'cogs and wheels' in the MOH Quality Care Cycle. Implementation will result in decentralization through provincial strengthening and review of adverse events, outreach, telehealth and supportive supervision and ensure a focus on learning from mistakes in a non-punitive and transparent manor.

1. INTRODUCTION

This policy aligns with key Vanuatu Government Acts and Ministry of Health Policy. It is an essential component in the broader government objective to decentralize services and the Ministry of Health mandate to strengthen Primary Health Care. A broad cross section of patients, community and staff have contributed to the evolution of this policy, driven by the National Policy Working Group chaired by the Director of Hospital and Curative Services.

Definition (WHO) - A **referral** can be defined as a process in which a health worker at one level of the health system, having insufficient resources (drugs, equipment, skills) to manage a clinical condition, seeks the assistance of a better or differently resourced facility at the same or higher level to assist in, or take over the management of, the client's case. Key reasons for deciding to refer either an emergency or routine case include:

- to seek expert opinion regarding the client
- to seek additional or different services for the client
- to seek admission and management of the client
- to seek use of diagnostic and therapeutic tools

In this policy, the facility that starts the referral process is called **the initiating facility**, and they prepare an **outward referral** to communicate the client condition and status to the receiving facility.

For successful referral, referral services are accessible, referral staff are trained to provide quality care, services are affordable, and essential drugs, supplies, and equipment are available. The most complex aspect of referral care is often the health workers acceptance of and compliance with a referral recommendation – especially when they may be the only staff in the village managing the clinical risk.

The timeliness of referral is key to preventing mortality in severely ill patients. This policy presents evidence-based principles required to achieve safe and effective transfer of patients. **However, it is beyond the scope of the policy to outline detailed guidance for the wide range of transfer circumstances seen within individual specialties. Unique referral circumstances for individual specialty areas should be made with the same high level of two way communication outlined in this policy.**

All permanent, locum, agency should adhere to this policy and voluntary staff of the Ministry of Health (MoH), acknowledging that for staff other than those directly employed by the MoH the appropriate line management or chain of command will be taken into consideration.

All patients within the MoH that require transfer from one area to another either internally or externally must have the appropriate documentation completed to ensure that patient care is not compromised as a result of the transfer.

In the event of a national disaster, infection outbreak, flu pandemic or major incident, the MoH recognizes that it may not be possible to adhere to all aspects of this policy. In such circumstances, staff should take advice from NDMO and the infection prevention team and all possible action must be taken to maintain ongoing patient and staff safety, however, the high standard of two way communication outlined in this policy should be maintained.

1.1 Referral System

***Internal Referral System* (PHC to Provincial Hospitals).**
This is a patient referral / transfer within province to enable enhanced care. Ideally, when the RDP is completely implemented, most referrals should be able to be managed within the province.

External Referral System (National referral Hospital)
This is where a patient is referred out of the province to receive further diagnostic investigations or emergency care elsewhere that cannot be provided at National Hospital. Senior Medical Officers (SMOs) determine if a patient benefits from a referral/transfer externally to another facility. This involves dialogue with the senior executive management team (Director of Hospital and Curative Services) and financial constraints may influence the ultimate referral decision.

International Referral System – in exceptional circumstances, a non-urgent/elective patient may be referred out of Vanuatu upon appropriate approval. Where patients elect to go to major regional/international/private hospitals (a self-referral), they then pay for the travel, treatment and investigations in these health facilities. **Expenses relating to travel for senior government officials will be the responsibility of Parliament and the Ministry of Finance. In this case, the MoH will provide clinical advice only.**

1.2 Retrieval Medicine

Patient referral also includes 'retrieval medicine'. Retrieval medicine is a critical component in patient care that forms pre-hospital patient management, which influences hospital care, as well as post hospital care and requires sound knowledge and skills in emergency medicine, anesthesia and critical care. A team may be required from the National or Provincial Hospital to go out to retrieve emergency and critically ill patients and those at risk of critical deterioration.

An emergency medical retrieval may be carried out via a fixed wing or by helicopter and clinical staff collect the patient and then return to Provincial or National Hospital.

1.3 Aim of a Well-Established Referral System

The criteria and process for patient referral across health services is outlined in this guideline for all health service providers and partners to understand and follow. A well-established referral system aims to:

- Avoid overcrowding at National and Provincial hospitals by patients who can be equally well managed at health facilities close to their homes, therefore saving scarce resources.
- Provide continuum of care where patients are referred back to their originating/initiating health facility with full information on their diagnosis and treatment plan.

The World Health Organisation (WHO) states that a good referral system can help to ensure:

- People receive ideal care at the appropriate level at lower cost,
- Hospital services are efficient and cost effective and
- Primary health services are well used with standards of service enhanced.

An effective patient referral system ensures close relationships between all levels of the health system are maintained and assists people to receive the best possible care closest to home. An effective referral system also assists in making cost-effective use of hospitals and primary health care services.

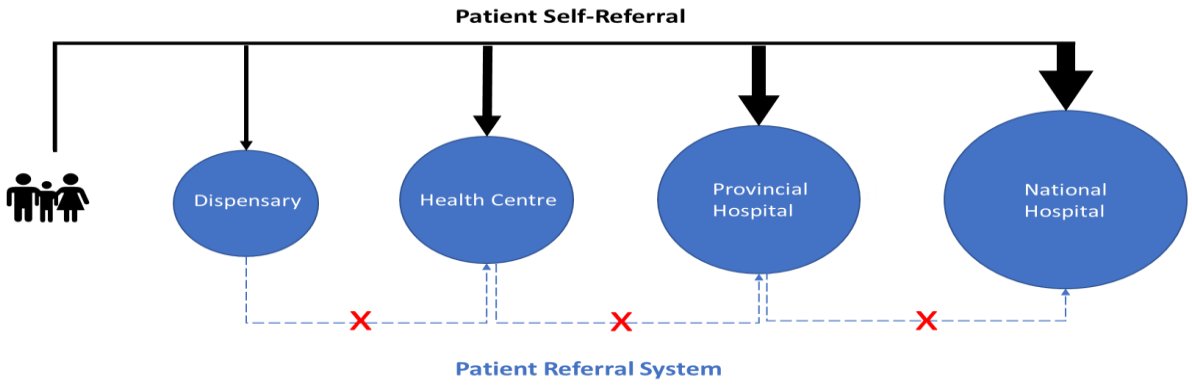
The remainder of this paper is structured as follows: section two reviews relevant background information concerning referrals. Section three describes an appropriate referral system, followed by four, which outlines the objectives of the national referral guideline objectives.

Vanuatu Ministry of Health is committed to providing quality accessible health care to all people living in Vanuatu. All health care providers are to refer patients appropriately to ensure continuous provision of safe patient care between all levels of health care within the province.

2 CURRENT SITUATION

The current referral system is inconsistently applied and approved. There is limited referral criteria to guide the health workers when referring patients. The absence of referral criteria leads to low acceptance rate, unnecessary and delayed referrals. There is also friction between some referring and accepting doctors, which at times puts the patients' lives at risk. There are no clear guidelines on who takes responsibility for documentation of patients who die on their way to referral Centre's. Some patients refer themselves from one level to another as they assume that they get better service at other levels. This leads to overcrowding and over burdening of the referral Centre's which end up handling patients who could otherwise be managed at lower levels of health care.

Figure 1: Current Patient Referral System



Currently, patients frequently bypass the first level of care mainly due to ignorance, inadequate primary health care facilities, lack of drugs and consumables or lack of confidence in first level health facilities.

Other factors making the patient referral system inefficient includes lack of standard guidelines for referrals (including proper referral forms), delays in referrals and poor perception of the system by referred patients and lack of feedback.

2.1 BACKGROUND

Vanuatu is an archipelagic nation of 83 islands, extending over 1000 kilometers in a north-south direction between the equator and the tropic of Capricorn. It lies some 2000 kilometers to the northeast of Brisbane in the Coral Sea, at similar latitudes to Cairns in North Queensland. The population of Vanuatu is approximately 272,000. Port Vila, on the island of Efate, is the capital.

Formerly known as the New Hebrides, Vanuatu was jointly governed by British and French administrations before attaining independence on 30 July 1980. The name "Vanuatu" is an important

aspect of national identity. *Vanua* means "land" in many of Vanuatu's one hundred and five languages, and translations of the new name include "Our Land" and "Abiding Land" and was core to independence.

Health services in Vanuatu is facing the challenge of being delivered in a predominantly island and rural country. As of 2019 the Vanuatu health services delivery system consists of 1 national referral hospital, 1 regional referral hospital, 4 provincial hospitals, 34 health centers, 91 dispensary and more than 245 Aid Posts. There are major problems that are negatively affecting the smooth running of the referral system; these are variables of transport, inadequate communication network, insufficient resources, inadequacy in numbers and skills mix of key health personnel, lack of equipment and insufficient level of infrastructure, and logistics. Factors predicting health care utilization varies, and similar barriers are found across Vanuatu particularly the cost and lack of transportation, the cost and perceived quality of medical services, unrecognized disease severity, difficult climate and geographical conditions. Currently, approvals for referrals do not sit with the specialists being referred to but rather with the finance team.

2.2 Human Resources

Currently, the recruitment and placement of health workers needs improvement, to ensure appropriate skill mix. The RDP articulates the ideal staffing skill mix, location and ratio. There is currently a mapping exercise being undertaken by the MOH planning unit to guide these decisions. In addition, the number of clinical specialists is insufficient, especially in rural areas. There is limited structured performance management and limited mentorship and ongoing education to upgrade the skills of health workers and opportunities for continuing education are limited.

2.3 Communication

Although there is a communication system in place, there are challenges of inadequate communication tools at some health facilities. As a result, information on clients being referred from one facility to the other is not properly communicated to the recipients. The mechanism of providing feedback on referred patients from one level to another is poor, because there is no structured referral system to do so. Patients are often referred without prior appointments (un-booked cases). This leads to inadequate space at provincial and national referral hospitals. There is also poor communication and consultation amongst some doctors, nurses and paramedics/allied health workers with regards to referrals of clients, which results in low acceptance rate by facilities and or unnecessary referrals.

2.4 Transport

Transport of patients is problematic with many risks to patients and staff. Road and Maritime routes are often inappropriate for safe transport and not well maintained. Patients often have to travel long distances to functioning facilities, thereby incurring high transport cost. Commercial aircraft are expensive and also leads to issues of depleting staff resources.

2.5 Equipment

Equipment for supporting transport such as monitoring and stabilization is extremely limited. Table 3 outlines minimum equipment and transport needed for referral.

2.6 Management of Referrals

There is lack of involvement in the arrangement or processing of referred patients by some heads of units in health facilities. The arrangement of referrals is managed by the staff at the finance office. Many patients are referred without initial work up being done. This results in increased length of patients' stay in hospitals and unnecessarily high bed occupancy rates. The specialist support to intermediate and provincial hospitals is inadequate, leading to unnecessary referrals. There is poor coordination of referrals between different levels of health service delivery, which causes delay in treatment of patients, and overloading of patient boats and trucks (ambulances). In addition, some patients overstay in hospitals due to poor coordination between ambulance/transport services and booking offices at different levels.

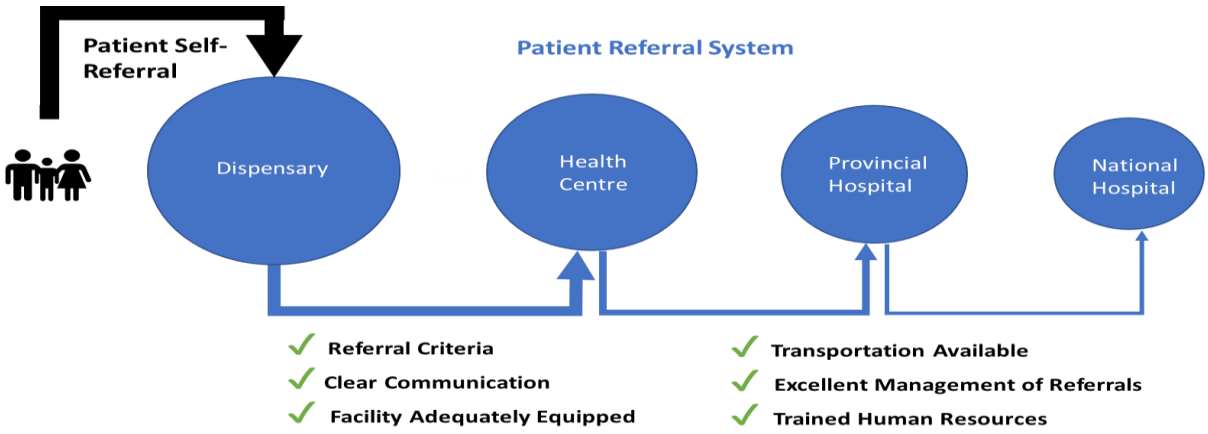
3 Appropriate Referral System

A good referral system should ensure that the appropriate equipment and skills are available at a provincial, regional and national level to treat complicated cases that cannot be adequately managed at lower levels of care.

As a result, there is a need for a formal referral policy, improved and strengthened communication strategies (especially feedback between all levels of care), improved transportation of patients by vehicles and boats that are always in a good running condition, and the provision of suitable training opportunities for all health workers at all levels of care. The problem of delayed referrals, referral of inadequately managed patients especially emergency needs to be corrected because both contribute significantly to morbidity and mortality in Vanuatu. In order to minimize unnecessary referrals, it is preferable that regional hospitals and health Centre's should be equipped with modern technology (including equipment, information systems), adequate and qualified staff in all six provinces.

Communication across the below continuum of care is essential. It may be appropriate to bypass a level of care if appropriate treatment is not available at the next level up or transport routes. (E.g. Directly from Health Centre to the National Referral hospital) However, this can only occur following consultation with the Provincial Medical team.

Figure 2: Appropriate Referral System

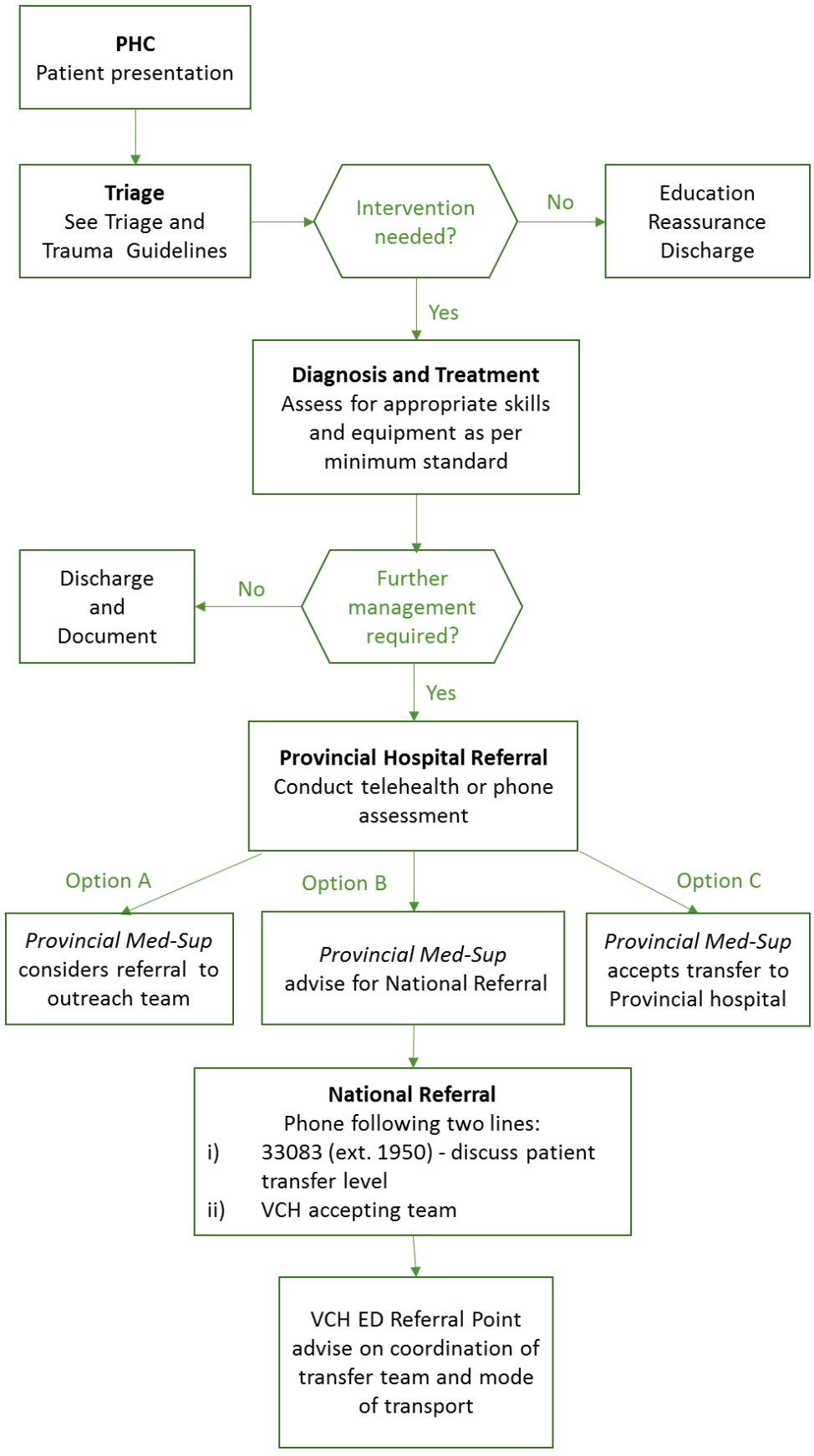


4 NATIONAL REFERRAL POLICY OBJECTIVES

1. **Ensure patients who requires referral, *receive timely and appropriate patient admission, assessment, care, treatment and referral* from the initiating health facility to the next level of care/most appropriate health facility level:**
    - All patients present to a health facility and are assessed based on triage with assessment as follows: chief complaint, general appearance, airways, breathing, circulation, disability, environment, history and co-morbidities (See Triage and Trauma Flow sheet).
    - Patient referrals are categorized as urgent (emergency) or non-urgent (elective) based on the severity of the patient's condition.
    - A standardized patient referral form (SBAR) is used for all patient referrals, completed by the initiating health facility and signed by the relevant health professional. Approval to refer to the next level of health services is also indicated on this form.
2. **Ensure appropriate *coordination and communication* between the initiating and receiving health facility.**
    - The *practice of patient referral* from the 'initiating health facility' to the next appropriate level of care, the 'receiving health facility' is *standardized.*
    - Clear coordination and communication mechanisms between all health workers involved in the management of the patients requiring emergency medical attention as well as non- urgent / elective patient referral exist.
    - Patients, who are referred to the receiving health facility, receive safe patient care and treatment in *transit* based on triage (degrees of urgency).
3. **Ensure that referral patients are *appropriately managed and receive safe patient care at* the receiving health facility.**
    - The health facility receiving the patient has the available skilled workforce, medicines and equipment to manage the condition of the patient.
4. **When a patient is *discharged* from the hospital or the rural health facility; the patient leaves, returns either home or is transferred back to rural health facility/ village for continuation of care, may require follow up/clinical review, rehabilitation, or support for palliative care.**
    - Patient discharge includes medical instructions, the supply of medications and consumables that the patient requires at the time of discharge.
    - Follow up care after discharge from Hospital/Rural Health Facility is documented on the Discharge Summary.
5. **Ensure the effective and efficient use of health resources in the assessment, treatment and care of patients who have an approved referral.**

This policy is designed to assist health services to manage patient referrals and to support appropriate, informed and timely access to clinical care. The National Patient Referral Policy is about making timely referrals based on clinical assessment, communication between different levels of care, approval to transfer, and supporting a patient's acute and ongoing care management, discharge and follow-up care.

Figure 3: Patient Referral Flow Chart



5 PATIENT ADMISSION

The National Referral Policy is designed to support the patient admission process. The patient admission process in this guideline ensures that once a clinical decision is made to admit a patient to a health facility, a standard process is followed. A standard process reduces variation to enable safe and appropriate clinical care at a PHC and Hospital Level

5.1 PRIMARY HEALTH CARE ROLE

Primary Health Care Setting when strengthened through training in appropriate referral and resourced against with the Role Delineation Policy will be the initial point of entry for all patients. (As per above flow diagram) Ensuring access to upskilling, supervision and support for all PHC staff will be essential in the implementation of this policy.

5.2 HOSPITAL ROLE

The Emergency Department

The Emergency Department (ED) is the point of entry to the hospital for emergencies. EDs have the capacity and capability to manage emergency/ trauma patients at the time of arrival without delay or interruption. Appropriate management of emergency patients includes Basic & Advanced Life Support skills with priority for regular upskilling of all health workers rostered to the ED as well as the opportunity for rural health workers/students on clinical attachment/placements to the ED for upskilling.

All ED patients who remain within this department for clinical treatment greater than 4 hours are admitted patients and a medical record initiated. ED patients who are on treatment and predicted to stay overnight (short stay), or as clinically indicated and transferred to a ward or discharged.

In Vila Central Hospital, the ED is operating 24/7 to manage all urgent/emergency referrals. The ED Emergency Physician or Emergency Registrar are the designated MOs at Vila Central Hospital. Hospital retrieval team (ED designated officers) receives the patient, travelling by air and receive a detailed clinical handover. Urgent/emergency referrals are Triage category 1, 2, 3 and 4 Triage category patients with non-urgent referrals Triage category 5. At peak times, Vila Central Hospital ED may have an overflow of Triage category 3-5 patients who are kept onsite for immediate treatment i.e. opioid pain management and IV therapy.

Survivors of Sexual and Gender Based Violence (SGBV) are seen in the Emergency Department and are managed as urgent case equivalent to Triage category 1-3. The ED team work closely with the Police, O&G & Pediatric teams to ensure comprehensive evidenced based survivor centered care are admitted as inpatients.

For Mental Health Services, medical officers are consulted regarding the admission of mental health patients. The Mind Care team are to be notified of all Mental Health referrals.

Maternity Unit Birthing Suites

Maternity Unit Birthing Suites operate 24 / 7 and is the point of entry to the hospital to manage all urgent *obstetric referrals / emergencies*. If a non-urgent referral a prearranged approval to refer and an appointment date is organized e.g. to the hospital Gynecology Clinic, Antenatal Clinic. Un-booked obstetric cases present to ED or to the Maternity Unit Birth Suite.

Ambulatory *Care*

Non-admitted non urgent stable patients with medical conditions i.e. NCD's / STI's / TB Clinic are referred directly to the Outpatients Clinics or relevant Specialist Consultation Clinic for medical consultation and treatment. A suspected HIV / AIDS or TB patient may require admission from these clinics. A patient who has an approved referral to the Specialist Consultation Clinic (e.g. Pediatric Clinic, Surgical Clinic) are seen within 1 – 5 working days of the patient arriving from the referring health facility, where possible, appointment times and date are pre-arranged for each patient.

Non-Communicable Disease

In alignment with the RDP, the MoH has established NCD's hubs in dense population areas. Where possible, all NCD's referrals should be made directly to the specialists NCD hubs for 'one stop shop' management of chronic disease.

Allied Health Services

Allied Health and Clinical Support Services include Physiotherapy, Dental, Medical Imaging, Pathology and Pharmacy who provide services to both inpatients and ambulatory care patients. Patients referred via Emergency Department and Birthing Suite access clinical support services based on hospital requests and approval, as do Specialist Consultation Clinics.

The formal patient referral process is followed for non-urgent stable ambulatory care patient and for referral to allied health and clinical support services. The patient pre-arranged referral is confirmed; the referral form completed along with the patient held record book accompanies these referral patients from rural health services.

5.3 Patient Records

Urgent/emergency patients referred to the ED, have a health worker escort, as per patient transport procedure, a completed referral form and Patient/Mother/Baby Held Record Book. The initiating health facility ensures that this patient has the completed referral form and patient held record so that the receiving facility has a record of the patient's history, clinical examination, investigations undertaken, and reason for referral.

It is essential that every pregnancy mother/girl has a 'Mother held record' book and every newborn/child as a 'Child health/Baby record' book supplied by MOH health services. Every adult patient is encouraged to have individual 'Patient held record' book. Every health worker is to encourage 'patients' to bring with them their record book for each presentation at a health facility and that these record books is kept in good condition.

There is a process in place for the Medical Records Department to retrieve any previous inpatient medical record from the Medical Records Department for each new admission.

5.4 Transfer of Patients

The transfer of patients admitted through the ED to respective Wards and/or the discrete transfer of deceased persons to the Mortuary is as soon as clinically indicated, as but not longer than 24hrs. The ED Medical Officers (Emergency Physician & Registrar) and other delegated ED staff (senior NO) consult with hospital Specialist Medical Officers (SMO) or Medical Officer (MO)/Medical Registrar to accept patients for admission to their respective Units.

6 PATIENT ASSESSMENT

6.1 TRIAGE

Triage of patients at all levels of the health service is essential to ensuring safe and timely quality care. The below is triage tools are a guide to assist the MoH to prioritize patient care.

Figure 4: Interagency Integrated Triage Tool

INTERAGENCY INTEGRATED TRIAGE TOOL

High-Risk Trauma Criteria	
General Trauma	**Road Traffic**
Fall from twice person's height	High speed motor vehicle crash
Penetrating trauma excluding distal to knee/ elbow with bleeding controlled	Pedestrian or cyclist hit by vehicle
Crush injury	Other person in same vehicle died at scene
Polytrauma (injuries in multiple body areas)	Motor vehicle crash without a seatbelt
Patient with bleeding disorder or on anticoagulation	Trapped or thrown from vehicle (including motorcycle)
Pregnant	
Burns	
Greater than 15% body surface area	Inhalation injury
Circumferential or involving face or neck	Any burn in age < 2 or age > 70

Threatened Limb
A patient presenting with a limb that is : -pulseless OR -painful and one of the following: pale, weak, numb, or with massive swelling after trauma.

Ingestion/exposure
Use of clinical signs alone may not identify all those who need time-dependent intervention. Patients with high risk ingestion or exposure should initially be up-triaged to Red for early clinical assessment.

Signs of Respiratory Distress	
Adult	Child
Very fast or very slow breathing	Very fast breathing
Inability to talk or walk unaided	Inability to talk, eat or breastfeed
Confused, sleepy or agitated	Nasal flaring, grunting
Accessory muscle use (neck, intercostal, abdominal)	Accessory muscle use (e.g., head nodding, chest indrawing)

- Red patients need immediate care.
- Yellow patients should be seen within site-specific target [consider 2 hours maximum]. Any Yellow patient not seen by target should be re-triaged.
- Green patients should become Yellow after 4 to 6 hours of waiting.
- All patients should be reassessed regularly.

Draft February 2019

Figure 5: Integrated Triage Tool for patients older than 12 years old.

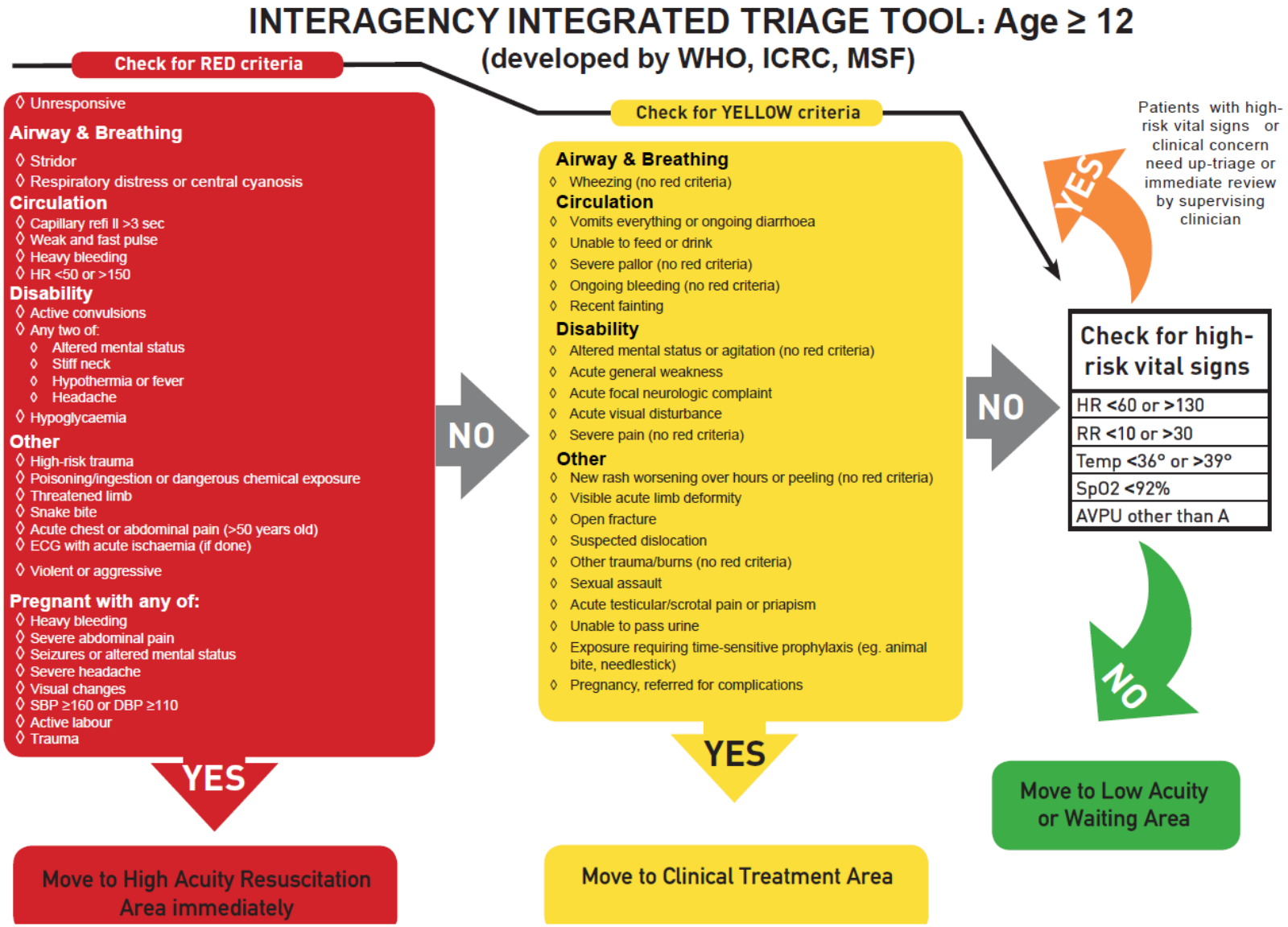
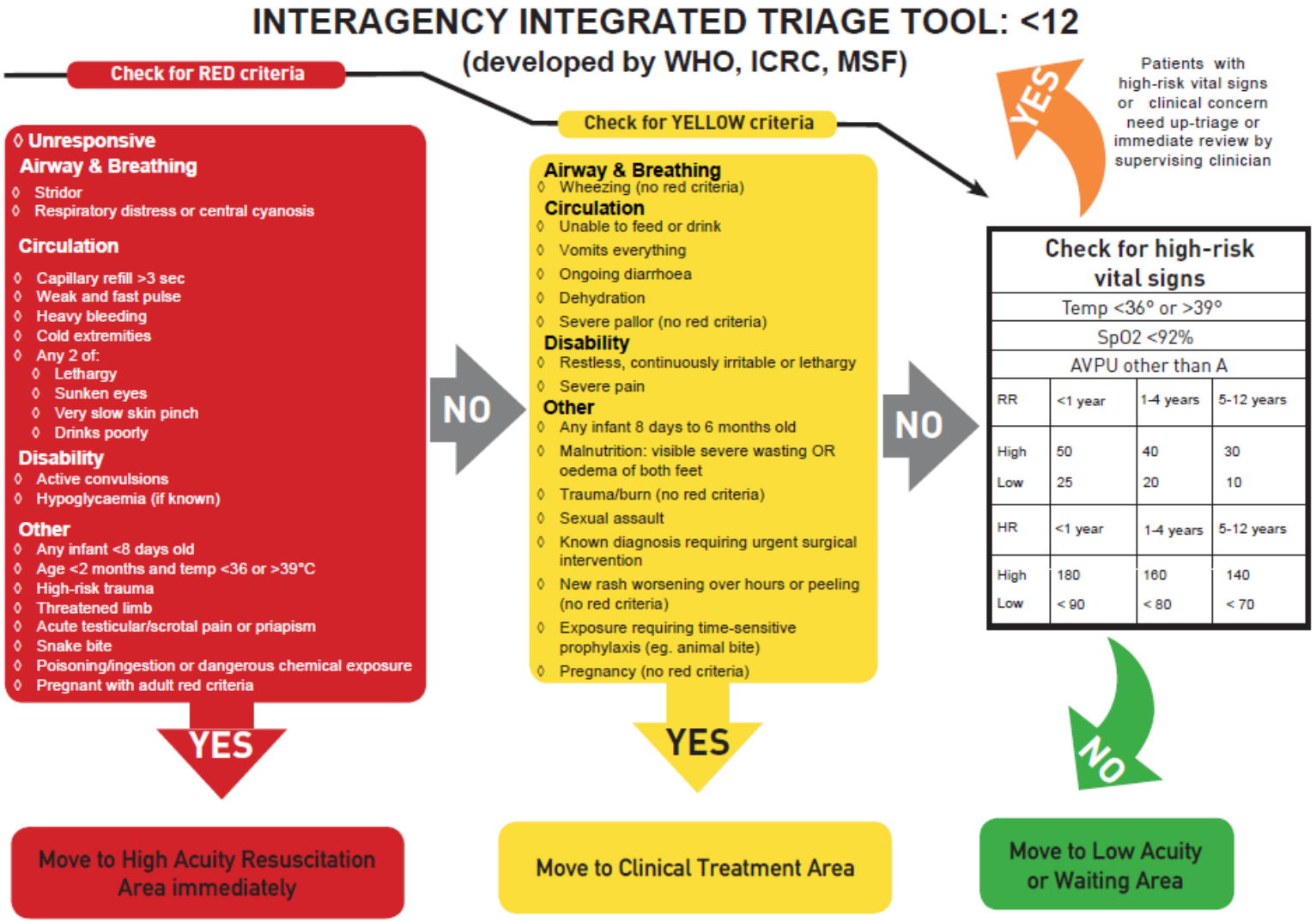


Figure 6: Integrated Triage Tool for patients younger than 12 years old.



Urgent and Non-Urgent
If the patient is NOT stable then the health worker responds immediately or takes action based on triage categories for treatment acuity.

For the purpose of patient referral, the non-urgent patient is managed at a rural health facility but may require further detailed investigations by clinical support services and/or specialist medical officer assessment, diagnosis and treatment. These patients are classified as stable or non-urgent.

7 PATIENT CARE AND TREATMENT

Quality Care Cycle incorporates a review of adverse events inclusive of patient care and treatment as directed by this policy. Review of Sentential events will be a critical component of the monitoring and evaluation of this policy.

The MoH is on the process of developing and reviewing Essential Services Packages, SOP's and Guidelines for Patient Management. All patient care in referral should be aligned with existing guidelines. Patient Referral

7.1 STANDARDIZED PATIENT REFERRAL FORM

The need for patient referral is documented on the 'Patient Referral Form' or SBAR and the form is signed by the initiating health facility Nursing Officer (NO) (unless at the Level 1 Aid Post by a Village Health Worker) who has received approval for the patient referral. If a health facility has no formal referral form, the officer documents detailed information in the form of a letter.

The SBAR is **fully completed** and includes relevant information i.e. name, age, sex, known allergies, presenting complaints, patient history (including regular medications and significant medical conditions). There is careful, accurate documentation of patient assessment, vital signs (including include time, Blood Pressure, Temperature, Heart Rate, Respiratory Rate and Weight (among others) and treatment given. The time of arrival to and the time of departure from the initiating health facility is noted as well as the time of arrival at the receiving health facility and time of patient clinical handover.

This form along with the patient held record book is given to the patient and/or escort (in the case of an emergency/urgent referral) and presented to the receiving health facility.

The SBAR is evidence of the approved referral and is signed by the senior nursing officer prior to the transfer of a patient to the next or appropriate level of health facility.

The SBAR includes a checklist to support health workers at the initiating health facility to prepare patients for transfer.

7.2 REFERRAL FOR PREGNANT MOTHERS - ANTENATAL CARE

During the pregnant woman,'s antenatal care (ANC), the midwife/health worker discuss with the patient the best place for a supervised birth and work with the pregnant woman/girl to develop a birth plan. Pregnant women who present at antenatal clinic and have no 'higher risk categories' are able to birth at Rural Health Facilities close to where they live, where the health facility has the capability to do so.

Any antenatal woman whose 'risk' changes during pregnancy requires an approved referral to a Medical Officer if clinically indicated. An appointment for clinical consultation with the Vanuatu Provincial Hospital SMO or Obstetrics & Gynecology Specialist Consultation Clinic is arranged between the initiating and receiving health facilities.

All Antenatal 'higher risk categories' should be referred routinely for 'sit down' period from 38/40 weeks' gestation at an appropriately skilled birthing center with access to an anesthetics operating suite if caesarian section is required.

7.3 Referral for Victims of Gender Based Violence

Domestic Violence, Intimate Partner or Family Violence occurs frequently, with survivors often not coming forward to seek health care. All levels of the health care system ensure that survivors of Sexual and Gender Based Violence (SGBV) receive comprehensive services - the best treatment, care and support. Providing the best treatment and support to survivors of SGBV includes patient referral to the appropriate Emergency Department as well as working as a multidisciplinary team with the Obstetrician & Pediatrician and ensuring a multi sectorial approach to address SGBV in prevention and justice for survivors.

Health workers working with survivors of SGBV, apply a survivor-centered approach, which means prioritizing the rights, wishes and needs of the survivor. The survivor requires an approved referral after clinical consultation; at the same time the agencies (initiating health facility) initiating and receiving SGBV survivors ensure a safe, confidential and consented referral between appropriate health and support services. The Five Essential Services for SGBV survivors at the initial point of access to a health facility includes treatment of injuries, and psychological first aid (PFA) and a planned referral to an Emergency Department for Prevention of HIV and STI, Pregnancy, Hepatitis B, and Tetanus.

The emphasis on safe referral is essential for not only specialist medical care but also other services, for example: welfare, legal, safe house, police, child protection, counselling, support and follow-up clinical care. Services to survivors of SGBV are free of charge and confidential health care is provided.

7.4 Referral for Suspected/Known TB Patients

When a patient diagnosis is unclear, it may be necessary to refer the patient to a Hospital Medical Officer for further investigations and diagnosis. The MOH National Referral Policy is followed with the following situations may require a patient referral for diagnosis:

- Only one out of three sputum samples tested positive for TB
- The patient is smear-negative but symptoms persist even after antibiotic therapy
- The patient has any persistent undiagnosed illness.
- Types of referral for Suspected/Known TB patients include referral to register and begin TB treatment and referral for special care.

Referral for special care relates to a patient who is very sick (urgent/emergency) and will present to the Emergency Department. Clinical consultation and communication between the initiating health facility and the receiving health facility TB Clinic/SMO/Physician is essential.

The patient has a standardized patient referral form (SBAR). It is important to record an accurate address in case the health worker needs to find the patient later; also record the address of someone known to the patient. Copies of this transfer form is as follows: a copy with the patient, a copy in the referral register and a copy to the TB Coordinator.

It is important that, when TB patients return to the initiating health facility to continue TB treatment, there is further liaison between clinicians to ensure and monitor the patient's treatment outcomes.

When a registered TB patient moves out of the area permanently, it is important to ensure that the patient will continue treatment after moving. An appropriate treatment health facility is identified in the new area and a referral initiated. If necessary, doses for several days of treatment for self-administration is provided. The patient TB Treatment card is also updated and the new address is recorded. A copy of the TB Treatment Cards is also provided to the patient. The patient presents to the next health facility with the TB Transfer form and TB Treatment card.

7.5 Referral for Mental Health Patients

There is adequate communication, clinical consultation and prior approval for the referral of mental health patients to a Provincial Hospital or as clinically indicated to the Vila Central Hospital Mind Care team. If a health worker/medical escort is required, prior approval is sought. SBAR is completed and includes relevant information i.e. name, age, presenting complaints, vital signs, treatment given and signed.

An urgent referral/emergency is classified as a person who is highly agitated, possibly violent, or is at high risk of suicide. When referred patients who are experiencing an acute episode of mental illness, it is important to include relevant underlying conditions that could be contributing to the mental health problem. There are often mixed clinical presentations with people who present with mental health difficulties.

- ✓ Mental health Patients can become increasingly agitated during transit and problematic in flight.
- ✓ Clinical consideration needs to be given to sedation prior to departure to avoid injury. Community management is always a preferred Model of Care.

7.6 Referral for Patients with Visual Impairment, Physical or Intellectual Disability

A senior nursing officer (NO) at a Rural Health Facility initially assesses patients with disabilities. Patients are then selected for patient referral to the Provincial /Vila Central Hospital to be seen by the relevant Specialist Medical Consultant for any elective surgery or further specialist consultation. The Patient Referral procedure is followed.

Referral for Patients with Visual Impairment

There is communication and clinical consultation between the referring Rural Health Officer and the Provincial Eye Medical Officer or other relevant Specialist Medical Consultants, seeking approval to refer. These patients may need a guardian / carer to travel with the patient. Documentation on the referral form is essential.

Referral for Patients with a Physical or Intellectual Disability

Persons with a physical or intellectual disability are often more vulnerable than other members of the community. A person with a physical or intellectual disability may require additional levels of support

when referred to another facility to achieve a positive outcome when accessing care. These patients may need a guardian / carer to travel with the patient and to stay with them until they are ready to be discharged from care. Documentation on the referral form is essential.

7.7 Referrals with Medico-Legal Issues

All requests for medico-legal examinations (i.e. rape, assault, etc.) is accompanied by an official request from the Police and other relevant authorities and in line with National Clinical Practice Guidelines for Medical & Psychosocial Care for Survivors of Sexual and Gender Based Violence. Medico-legal requests not within the capability of the initiating health facility should immediately be referred to the appropriate level. All Medico-Legal records must contain complete data such as date and time of incident, findings and management. The attending health professional (Medical Officer (MO)) must write his/her name, sign and stamp all medico-legal documents. A copy of the Medico-Legal report is kept in a file at the health facility.

7.8 Referrals with Accompanying Guardian/Relative

Where there is an approved referral and an accompanying guardian/relative or health worker traveling with a patient, the following is applied:

- A referral approval is required for one relative to accompany a patient and especially for those patients who are less than 16yrs old, above 60yrs old, visually impaired or with a physical or intellectual disability.
- The accompanying guardian name and contact details are documented on the patient referral form.
- There is no allowance for the guardian / carer apart from the above listed situations.

7.9 **Non urgent referrals -** *key principles*

- The first point of contact may be an Aid Post, Community Health Post, or Health Centre/NCD hub. Patients who require non urgent referral, receive *timely and appropriate patient assessment, care, treatment and referral* from the initiating health facility to the next level of care/most appropriate level of care to access Pathology, Radiology or consultation with a Specialist Medical Officer or appropriate health professional.
- At the initiating health facility, these patients are not turned away or refused, and the patient receives the best care possible for the level of service provided.
- If the patient referral is categorized as, non-urgent based on the patient's condition and clinical assessment, approval to refer is initiated.
- As much as possible, there is coordination and communication mechanisms between all healths workers involved in the management of the patients requiring further medical attention as non-urgent patient referral.
- Approval to refer to the next level of health service is obtained and indicated on the SBAR
- Specialist Medical Consultation Clinics is the point of call for all non-urgent referrals with liaise with the Nursing Officer who coordinates the appointments for Specialist Consultation Clinics and Allied Health Service providers.

- The approval to refer and the referral form outlines the pre-arranged appointments/booking for patients from Rural Health Facilities and Urban Clinics to Specialist Medical Consultation Clinics/Allied Health Services.
- The Specialist Consultation Clinics are conducted separately to the ED.
- The patient meets the cost of non-urgent referrals, unless in exceptional circumstances and that the MOH senior executive management makes decision.

8 PATIENT DISCHARGE

The National Referral Policy is designed to support the patient admission process as well as the patient discharge and follow up process. Vanuatu Provincial discharge destinations are rural health facilities, urban clinics, or home. The discharge of a patient is seen as part of the continuum of care and linked to an appropriate formal referral process. The intent of the National Referral Policy is that a patient who goes home and who requires follow up care receives it. The types of patient discharge include:

- Discharged home well
- Discharged home and requiring follow up care (i.e. patients with chronic illnesses, requiring terminal care, post-surgery)
- Transferred to another health facility within province
- Cases transferred beyond the province or overseas.

8.1 CONTINUUM OF CARE

The Patient referred from the Provincial Hospital who requires continuity of care at a Primary Health Facility has their care needs communicated with the senior officer at the rural health facility who is to receive the patient and provide ongoing patient care. This communication between facilities is to include the expected discharge date, patient transport need and requirements for follow up treatment. The discharging clinician also specifies the date, time and place that the patient is to attend/return to the Provincial Hospital for review.

A one-month supply of medications and consumables are given to patients discharged from the Provincial Hospital / Health centers to home.

Rural Health Facilities receiving patients from the Vanuatu Provincial Hospital are required to have ongoing clinical consultation with the Provincial Hospital Specialist Medical Officer and the Hospital Pharmacy to plan ongoing clinical care and access and plan the distribution of medicines and supplies.

Patients who require rehabilitation at the Rural Health Facility or at home are referred to the Allied Health Services available at the NCD hubs where they exist such as Physiotherapy, nutrition and primary eye care programs.

8.2 DISCHARGE DOCUMENTATION:

Discharged patients who require follow up care and who are transferred to another health facility for continuity of care, have a **standardized discharge summary** form including a treatment plan, required medications, consumables, and patient and guardian education. The Discharge Summary travels with the patient; the discharge summary information is summarized on the Patient Admission Discharge

Inpatient Medical Record Form, with a detailed summary in the inpatient medical record progress notes as well as the patient held record book.

Required documentation in more detail:

- All discharged patients require a medical discharge summary completed on the 'admission, discharge form' in the inpatient medical record upon discharge.
- Patients who require follow up care at a Provincial Hospital; have an appointment organized by the Vanuatu Provincial Hospital to be seen by the relevant Provincial Hospital Medical Officer, or a designated Rural Health Facility (NO). An appointment card (date and time) is given to the patient along with the written Patient Discharge Summary and Patient/ Mother/Child Held Record Book.
- Each Rural Health Facility maintain a Patient Discharge Referral Register as part of documentation for patient care review and continuous quality improvement.

The Health Information System will retain data / copy of documentation on all patient referrals.

8.3 Repatriation:

MOH does not cover repatriation costs and vies this as the client contribution to the referral costs. The discharge summary provides critical information regarding a patient's condition for those patients discharged and transferred back to a health facility for continuity of care.

Death

In the event of a death in hospital of a patient who has been formally referred from another health facility, the treating clinician notify the OIC of that health facility who initiated the referral of the death to the adverse events committee.

MOH delegate, Director of Hospital and Curative Services approves case by case for the repatriation of a deceased person. The deceased patient has a death certificate issued by the relevant Hospital Medical Officer within a day of the death.

The return of a patient back to a rural area need not be delayed following discharge if there is an appropriate referral and a planned discharge process to ensure continuity of patient. The Patient Admission Discharge (SBAR) form is fully completed on discharge.

9 Interaction, Coordination and Communication

9.1 Standardized Practice of Patient Referral

To meet the conditions in the National Referral Policy, clinical consultation is required between facilities initiating urgent (emergency) and non-urgent stable patient referrals. If a receiving health facility health worker i.e. NO/MO does not answer a call i.e. the call is not answered on the second call, this is referred and reported to the Medical Superintendent of VCH.

The decision to transfer a patient rests with the receiving health facility clinician based on the patient assessment and subsequent consultation and communication with PHC clinicians.

Urgent patient requiring air/helicopter retrieval requires approval by the MOH executive or delegate i.e. Director of Hospital and Curative Services.

The policy aims to ensure that patients receive timely, appropriate and well-documented clinical care. A Medical Officer (MO) authorizes admission; where there is no MO, a senior Nursing Officer (NO) makes the decision that a patient requires admission for appropriate treatment, care or further assessment of clinical needs. A standardized **Patient Admission Discharge form** is utilized.

9.2 Coordination and Communication Mechanism

MoH PSTN: 33083 Extension#: 1950 will be utilized for all health facilities in Vanuatu for all patient referrals, to seek approval to refer, and seek advice on emergency and/or non-urgent patient management. The aim of the toll-free mobile is to enable effective communication between the initiating and receiving health facilities.

Vila Central Hospital ED Emergency Physician or Emergency Registrar is identified to provide clinical consultation between Provincial Health Facilities and the Vila Central Hospital to assist with clinical decision-making and to liaise with hospital Medical Officers (SMOs) for approval to receive patient referrals from provincial centers. The ED Emergency Physician hands the phone over at the Registrar when not on call as the ED Emergency Registrar is the next on-call clinical contact person in this department.

For obstetric referrals/emergencies, Rural Health Services' call the toll-free mobile number or the SMO O&G. If the call is directed to the ED Emergency Physician or Emergency Registrar, they liaise with the O&G SMO or registrar for all O&G urgent/emergency & non-urgent referrals. All O&G referrals from rural health services follow this National Referral Policy

Documented communication between referring health facilities accompanies the patient. The patient is referred with a formal standardized patient referral form and the Patient/Hospital Card. The referral form includes the name, designation and contact telephone of the initiating health facility health worker.

After receiving care, the patient is discharged with a formal patient discharge summary and the Patient Card, which includes the name, designation and contact telephone of the discharging officer and instructions for continued patient care.

9.3 Documentation

Documented communication between referring health facilities is critical for delivering efficient and quality care. Previous sections have discussed numerous forms and records that are needed. Table 1: provides a summary of necessary forms & records needed for different steps of the referral process.

Vanuatu MoH health workers are also required to complete the Patient Referral Registers, which are maintained for monitoring and evaluation of internal and external referrals in all Vanuatu MoH health facilities

Table 1: Patient Records for Referral Process

Steps in Process	Patient Provides:	Facility Provides
PHC facility refers patient to hospital	Early presentation to enable safe and appropriate management	• Patient Referral Form (SBAR)
Admission to Hospital	• Patient Record Book • Patient Referral Form • For pregnant women: Mother Record Book • For newborn / babies: Child/Baby Record Book	• Inpatient Medical Records
Discharge from Hospital	• A standardized discharge summary	• Patient Discharge Summary • Appointment Card
Referral with Guardian	• A Guardian Referral Approval Form	

9.4 Responsibilities and Referral Pathways

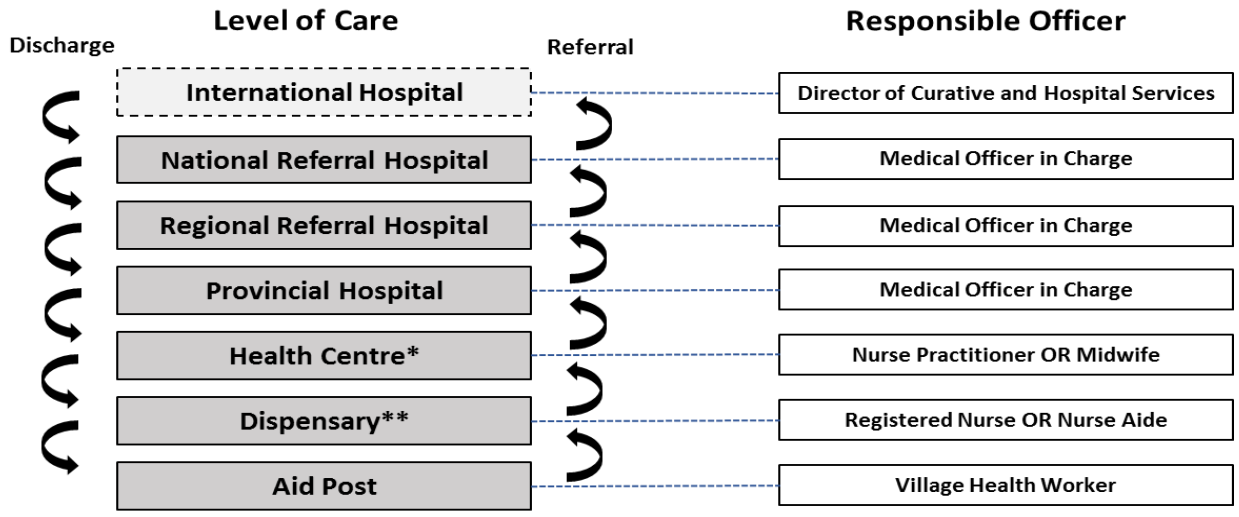
For effective communication and increased accountability, it is important that clear responsibilities be established. This will need to be undertaken at a provincial level and reviewed in provincial executive meetings. Figure 7: presents an overview of responsible officers for different types of referrals.

Aid Post

A Village Health Worker (VHW) from Aid Post would only be referring to the next rural health facility i.e. Dispensary or Primary Health Centre.

Where VHWs report maternal and infant deaths in communities, these deaths must be investigated, and Maternal and/or Perinatal Death forms completed and forwarded to SMOs Obstetrician and Pediatrician.

Figure 7: Responsibilities by Level of Care



Dispensary / Remote Dispensary

Initiating rural health facilities are receiving and accepting community-based referrals from Village Health Workers / Community based treatment partners and Aid in Kind organizations

It is important that health workers from Aid Posts, Primary Health Centre's, and Outreach teams work cooperatively with VHWs/aid in kind organizations and support them in their roles of connecting people with the health service, health promotion, and liaison between community and the health facility.

Health Centre / Enhanced Health Centre

As per Dispensary level as well as direct referrals to appropriate care. Enhanced Health Centre's will in coordination directly refer to National Referral hospital based on equipment requirements for diagnosis and transport routes. **This can only be initiated following communication with the provincial hospital**.

Provincial Hospitals

Non-urgent patients are referred initially to a Provincial Hospital where the Nursing Officer will screen and assesses the patient and communicate with the appropriate Provincial Hospital Senior Medical Officer (SMO) or Medical Superintendent to arrange an appropriate appointment date. This may include outreach and outpatient appointments with Specialist Medical Consultation Clinics, Dental, X-ray, Laboratory, and Allied Health services. Diagnostic investigation and / or ongoing treatment makes an impact in patients work, their health and wellbeing in life. This may mean that if patients do not complete a particular treatment and investigation that their medical conditions may worsen or cause permanent disabled. A particular treatment, elective surgery or investigation is important. Often these investigations i.e. blood tests, X-rays, are not provided nor available at a rural health facility nor at a provincial hospital and patients require referral; these are non-urgent referrals.

National Referral Hospital

This is the highest level of health care, which provides highly specialized health care services. It links up with other national and international health care providers. Its functions include:

1. Provides highly specialized services including international referral (b) In consultation with other levels of health, sets national standards for quality patient care
2. Provides specialist outreach support services to provincial hospitals.
3. Provides secondary and tertiary health services
4. Conducts specialist support outreach services to the provincial level
5. Conducts operational research for service improvement
6. Promotes networking with other health care providers
7. Conducts consultative meetings with private health care providers and establish referral procedures including air transportation of patients
8. Provides clinical and practical training for attached students
9. Conducts scientific research
10. Provides clinical and practical training for attached students
11. Conducts specialized forensic pathology services
12. Conducts scientific and operational research.
13. Monitors, evaluates, and reviews the functioning of the referral system.

Overseas Hospital

In exceptional circumstances when clinical services are provided in Vanuatu and when clinically indicated, to refer patients overseas for tertiary level medical services. Medical Evacuation / International Referrals have significant financial implications for both emergency and elective patients. MOH cannot afford international or overseas referrals and emergency medical evacuations. Thus, MOH does not fund referrals to or repatriation from overseas medical services. However, if the patient or relatives can afford then the MOH assists through approval of the MOH Director of Hospital and Curative Services in organizing the referral and contacting appropriate overseas health facilities. MOH may assist with medical equipment and medical escort if required for the transfer or referral. MOH Director of hospital and curative services is required to approve any referral out of Vanuatu in exceptional circumstances.

10 PATIENT EXPECTATIONS AND COMMUNITY RESPONSIBILITIES

The National Referral Policy has been developed to assist patient access to appropriate medical services not available at their nearest health facility. All patients must first be seen at the nearest primary health facility for initial patient assessment, treatment and care. Resuscitation and stabilization are to occur prior to referral. If a referral is necessary then there is formal communication and clinical consultation between initiating and receiving health facilities. A referral is organized by the Nursing Officer (NO) and approved by the receiving health facility worker (MO or NO). An official referral form SBAR is completed and signed with the contact telephone number of the referring health worker.

Assistance is provided for transport to the next appropriate health facility for urgent/emergency care. For all non-urgent referrals, bookings are made for prearranged, approved appointments and a completed referral form accompanies the patient. Each patient must take their patient held record book and completed referral form to their booked appointments.

Patients who are referred to Vanuatu Provincial Hospital needs to be aware of possible hospital/procedural fees that may be incurred during further treatment, such as further investigations, pathology, x-ray or surgery. A list of possible costs for further treatment needs to be developed are provided to patients to enable informed decision-making. Patients have the right of refusal, but the treating health worker must explain the impact and health consequences of not receiving further clinical investigations or medical treatment.

Members of the community are encouraged to have in place a community transport plan in case of emergencies in a village. This is vital for supporting pregnant women/girls who access a rural health facility for a supervised delivery. Village health committees are encouraged to have in place local community schemes to assist families in need during such emergencies.

Any member of the community can access medical care where they wish and bear the travel expenses incurred in doing so.

To create a functional referral system ***patient education and community awareness*** needs to occur. Patients are encouraged to go to their nearest health facility when they are sick. Those who live near an Aid Post must first go there and not to more distant higher-level health facilities. Patients living closer to a hospital are encouraged to present to the urban clinics.

Patients who present to a service who needs care beyond the health services' capability are referred to the next most appropriate level of care. The provincial health centers and provincial hospitals are the major referral sites for patient management. Provincial hospitals are being developed with a

greater range of services and will have the capacity to provide emergency care, surgery, pathology, x-ray and inpatient care. Provincial hospitals will remain accessible and work towards increasing their ability to retain patients so that less patients are referred to the Vanuatu Provincial Hospital.

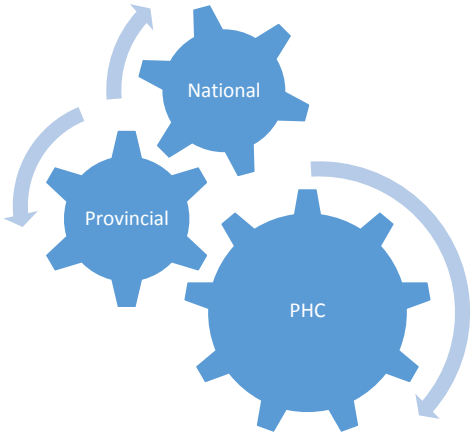
Access to transport is possibly the most significant determinant of self-referral to a health service at which the patients present. It is often easier for people in some areas to get transport directly to a Health Centre and bypass an Aid Post; this is considered in the approval of a patient referral.

Self-Referral
Patients may bypass their local rural health facility and travel directly to the Provincial Hospital/Urban Clinic/other Provincial Hospitals for outpatient services. This type of patient is a 'self-referral'.

Community members have access to all health facility outpatients and hospital emergency departments. However, Communities are made fully aware that self-referred patients who bypass the primary and secondary levels of health care are not entitled to funding support for the referral.

11 Administrative Support for National Referral Policy

Figure 8: Outlines the critical relationship between PHC as well as National and Provincial referral pathways



11.1 Patient Transport Services

Different communities have different capacity to transport patients to receive clinical care and to return to communities after receiving treatment.

It is the responsibility of the facility initiating the referral to organize transport for their patient to arrive safely at their referral destination (health facility). The preferred patient transport option for urgent patients is with the referring health facility road vehicle (ambulance). Non- urgent patients travel using a variety of means such as buses, or private community transport.

In the case of air transfers, it is the responsibility of the facility initiating the referral to have made contact with the receiving facility to arrange the collection of patients from the designated airport. In Vanuatu, arraignments are with the fixed wing provider, patients must have approval and a completed patient referral form to travel via air. The fixed wing provider will work with the Hospital Emergency Department to an agreed collection point to bring the patient from the airport into the receiving health

facility. Any patient referred by air during an emergency should not expect to be repatriated home by air.

Patients being discharged from provincial hospitals back to health centers, dispensaries or aid posts for continuing care are responsible for the costs of returning home. Where possible a provincial health facility provides support in terms of arranging a vehicle or a patient's family to collect the patient. In provincial locations, facilities receiving a patient may be a health centre, community health post or an aid post.

Referral patients in Transit

When patients have poor prognoses and based on a clinical decision between the initiating and receiving health facility health care professionals, these patients may not be referred for further treatment or investigations. It is important to remember that the outcome of the patient's clinical condition may worsen during transfer; consequently, the clinical care judgement is essential.

Road and small boat travel can be difficult and long, patients should be able to withstand the difficult road and ocean conditions and not significantly deteriorate. In other words, patients should not die in transit.

11.2 Village Health Workers as Escorts

In Vanuatu, Village Health Workers (VHW) are an integral component of PHC but to date remain an unregulated part of the Health Services. The recently revised VHW Manual guides VHW scope of practice. As clinically indicated, a village health worker may be required to escort an urgent patient to the next level of care. Approval is sought for the escort to travel prior to the transport of the patient and practice is alignment with the VHW manual.

A health worker who is required to escort a critically ill or trauma patient must have the appropriate clinical skills and have access to essential medical equipment to manage the patients during transit. The health worker must return to the initiating health facility as soon as possible after the clinical handover. All staff must adhere to the Patient Transport Guideline.

The ambulance driver is also required to have basic first aid training and demonstrate safe driving skills.

If an overnight stay is required by the escort/driver, the receiving health facility is required to organize an overnight stay as part of the referral/escort approval process.

Medical, non-medical or relatives as escorts may be required for external patient referrals. MOH Executive Management team will consider case by case based on clinical advice from the relevant SMO.

MOH Worker Work Related Injuries

MOH employees may experience work related injuries during the course of executing their duties and the following applies:

- The injury or emergency condition is appropriately treated at the closest health facility in the first instance.
- The health worker who has serious injuries is referred as soon as practical to Provincial Hospital for further treatments.
- The clinician and the management prior to referral determine mode of transport to the Provincial Hospital.

- MOH meets the cost of treatments and travel arrangements if the treatment or investigation is not available in Provincial Hospital. Alternatively, the treatments could be brought to the patient from outside by the MOH. The senior clinician and the senior executive management make the final decision-based patient's condition and the expected treatment outcome.

All staff injuries are reported to the National Executive team for ongoing follow-up and evaluation

11.3 Supportive Supervision, Medical Outreach and Capacity Building

Provincial Hospital Specialist Medical Officers work together to plan and conduct Rural Clinical Outreach, providing medical outreach support to the Provincial Health Facilities within the Province. Specialist Medical Officers provide supportive supervision and medical outreach programs to the rural health facilities enabling Officers in Charge to plan priority patient appointments and reduce the need to refer to Vanuatu Provincial Hospital particularly for non-urgent or review cases. When a patient returns to the community following care at the provincial hospital, patients receive ongoing care from quarterly specialist medical outreach visits that are scheduled at rural health facilities.

MOH through the Provincial Medical Superintendents and Nursing Officers monitor compliance of the Patient Referral process during their quarterly supervision visits to rural health facilities and follow up any concerns in regard to the National Referral Policy, especially where there has been a cost incurred by the health facility or where there has been an increase in inappropriate clinical referrals or poor patient outcome to a hospital emergency department.

Provincial Medical Superintendents also have a role in supportive supervision and to coordinate with the Specialist Medical Officers when undertaking rural health services supervision. When undertaking rural health supervision or rural clinical outreach, onsite health worker upskilling is considered an essential component.

MOH work with health service delivery partners to deliver training to support the implementation of the Patient National Referral Policy and clinical education to build the capacity of rural clinicians and for rural health facilities to reduce the number of patients referred to the next level of care.

Within MOH, it is the responsibility of the Public Health Program Officers, Medical superintendents and Nursing Officers in Charge to carry out regular local supervision, training and capacity building in each Provincial Rural Health Facility.

Upskilling is based on best practice evidence, Vanuatu Standard Treatment Manuals/Guidelines and available literature. Where there are patient care practice deficiencies, there is a planned approach for health workers through clinical attachments at a functional Provincial Hospital or at Vila Central Hospital. Alternatively, VCH through their Health Training Unit/Coordinator conduct clinical programs at provincial level for example the Emergency Department Senior Medical Registrar may conduct the Primary Trauma Care Program (including emergency management of airways, breathing, circulation and drug management, and may include pain management, primary trauma care, pediatrics and acute care) within each province.

11.4 Adverse Events Committee

The members of the adverse events Committee work together to ensure mutual obligations regarding the review of the MOH National Referral Policy. This is outlined in the Terms of Reference of the committee and Adverse Events Policy.

11.5 Continuous Quality Improvement

Continuous Quality Improvement aims to regularly review patient outcomes and contains mechanisms to prevent health system performance from slipping below minimum standards and to promote continuous improvement in all activities. Quality improvement is the responsibility of all Medical Superintendent, clinicians and all members of staff in accordance with priorities and directions established by the National MOH Executive Management team.

Two key initiatives are core to improving Clinical Systems are:

- Risk Management (Preventing harm to patients, staff, facilities and the health service) and
- Continuous Quality Improvement (further developing a health service, its people, systems and processes, and infrastructure to be even more effective than they already are).

The National Referral Policy encourages Provincial Medical Superintendent with the OICs of rural health facilities to adopt Clinical Governance/Clinical Standards, review mechanisms, and escalate to the Adverse Events Committee.

In addition, Workplace Health & Safety committees need to be established to review, discuss, and reduce the risks involved with patient care, patient referrals, health facility staff and the community.

In implementing the National Referral Policy, health facilities are asked to look for ways to reduce:

- Inadequate care of patients prior to patient transfer,
- Poor outcomes 'in transit',
- Breakdown in communication during clinical handover in the referral of patients,
- Patient confidentiality i.e. the correct patient information only shared with who need to know,
- Delays in clinical care at the receiving facility or delays in the patient being transferred from one level of care to another in a timely manner,
- Risks to patients, staff, patient families, escorts and guardians during road and air travel,
- Critical incident documentation, investigation, monitoring and reporting and
- Clinical Audits of poor patient outcomes.
- Issues of access because of local circumstances not articulated in this policy.

Other related quality improvement activities may also include review of vehicle logbooks and fuel records as well as review/audit of patient referral forms and discharge summaries for accuracy of information.

A list of data and information on patient referral is collected, analyzed and reported at Rural Health Facilities, at Provincial/National Hospital level; utilizing data sources such as the patient referral registers, patient medical records, outpatient summaries, morbidity data, and admission data. Referral forms are audited for compliance with the referral guideline. Interviews with patients, health workers and focus groups contribute information on the effectiveness of or problems with patient referrals.

The MOH Clinical Governance/Clinical Standards & Patient Care Adverse Events Committee receive reports on referral information, analyses, strategies and recommendations via Provincial Hospitals and rural health services on at least a quarterly basis.

Confidentiality

All health facilities patient health data contained within the medical record and the Hospital/Rural Health Facilities information system and registers are private, confidential and are not divulged to anyone except to the clinical staff responsible for the care of the patient and those hospitals/rural health staff involved with the processing of patient information. The patient referral form and discharge summary are provided in a sealed envelope.

11.6 Role Delineation of PHC Settings

In order for health workers to facilitate the appropriate referral, it is important to understand the capacity and role at each level of health care. Role Delineation Policy determines the type of services, allied health and support services, health worker profile (skill mix, workforce productivity), minimum standards and other requirements to ensure that clinical services are provided safely and appropriately supported. Health service delivery networks and networking needs are considered together with patient referral patterns, patient flows, and population clusters and transport infrastructure (road and air).

The role of each level of health facility has been clearly defined in terms of capability - level of clinical care, expertise, resources, roles and function. Role Delineation Policy of Health Services in Vanuatu matrix outlines each level of health service.

11.7 Monitoring and Evaluation

The Patient Referral System within MOH requires assessment and review, both for the effective formalized patient referral system and the capacity of the MOH health facilities and partners. It is recommenced that once the National Referral Policy is fully implemented, there is an annual review and as required the Policy updated. This monitoring of patient referral activities and review is essential to ensure that the patient referral process remains relevant, efficient and on track.

This policy will be reviewed in response to Provincial or National initiatives or as advised by the adverse events Committee through the Director of Hospital and Curative services.

12 Financial Implications of Patient Referral Policy

The cost of an inappropriate health care system is significant. In 2018, a total amount of 77,000 VT was expended on Indirect Medical Cost (Transfer and Accommodation Cost) related to Referrals, which is equivalent to 2.1 % of the Total Health Expenditure (2.77Mil VT). This does not include the subsistence allowance paid to transport staff.

The Patient Referral Policy is expected to reduce this financial burden for the Ministry of Health. The main reasons for this reduction in financial expenditures are:

- A reduction in the Number of Patients Referred to National Referral Hospital (30%)
- Increase in Patients that use Commercial Flights versus Patients that use Charter flights (10%)
- Increase in Patients that use Surgical Operation (only urgent cases will be referred) (10%

- Reduction in the number of days with Escort (4.7 days to 2 days)
- Increase in the number of referrals that are using Paramedical for referrals (30% of referrals for which an Escort is required is expected to use Pro Medical services)

The impact these changes have on the total number and type of referrals are shown in table 2.

Table 2: Impact of Patient Referral on number and type of referred cases

Parameter	Pre-Referral Policy	Post-Referral Policy
Annual Number of Patient Referrals	350	245
# of Patients using Commercial Flights	250	200
# of Patients using Charter Flights	100	46
# of Patients requiring Surgical Procedures	280	221
# of Patients required non-surgical procedures	70	25
Patients with Escort (MOH)	245	120
Patients with Escort (Pro Medical)	0	51
Patients without Escort	105	74
Total number of escort days	1152	240

The cost, both direct medical and indirect medical cost are presented in Table 3. The medical cost of surgical procedures is taken from a Hospital Costing Study conducted by AusAID HRF in 2011 (insert reference).

Table 3: Unit Costs for Medical and Indirect Medical Cost

Type of Cost	Description	Unit Cost in Vatu
Direct Medical Cost	Surgical Cost (Total)	VUV 108,000
	Pre-Operative Care	VUV 5,000
	Cost of Surgical Care	VUV 65,000
	Post- Operative Care	VUV 38,000
Indirect Medical Cost (Transfer & Accommodation)	Commercial Flight (excl. Escort)	VUV 23,000
	Commercial Flight (Incl. escort)	VUV 69,000
	Average Cost Pro Medical Escort	VUV 15,000
	Charter Flight	VUV 220,000
	Daily Subsistence Allowance	VUV 5,000

Table 4: Financial Impact Referral Policy

Type	Sub Type	Pre-Referral	Post-Referral
Direct Medical Cost	Surgical Procedures	VUV 30,240,000	VUV 23,814,000
	Non-Surgical Procedures	VUV 350,000	VUV 122,500
	Sub - Total: Direct Medical Cost	*VUV 30,590,000*	*VUV 23,936,500*
Indirect Medical Cost	Transport Cost - Commercial Flights	VUV 13,800,000	VUV 11,012,400
	Transport Cost - Charter Flights	VUV 22,000,000	VUV 10,010,000
	Transport Cost - Pro Medical	VUV 0	VUV 771,750
	Accommodation/ DSA Cost	VUV 5,757,500	VUV 1,200,500
	Sub-Total: Indirect Medical Cost	*VUV 41,557,500*	*VUV 22,994,650*
Total Cost		***VUV 72,147,500***	***VUV 46,931,150***

Table 4 presents the total cost savings of the referral policy. When implemented correctly, the policy could reduce expenditure on referrals with 35% on a yearly basis, equivalent to 25 million VT.

13 CONCLUSION

The National Referral Policy is for those patients who access health facilities closer to home seeking clinical care and treatment and who require further clinical care to the next or most appropriate level of health service. There is communication between the initiating health facility and receiving health facility including clinical consultation and approval to refer.

The Guidelines within this Policy are like maps, directing patients and health workers through a patient referral process. There is a quality improvement process to ensure patient outcomes are reviewed and costs are acquitted appropriately.

In order to effectively implement this policy, provincial strengthening will be required in the areas of adverse events review, outreach policy inclusive of telemedicine and supportive supervision visits.

Implementing the 'wheels and cogs' of the MOH Quality Cycle will also ensure a focus on learning from our mistakes in a non-punitive and transparent manor.

There are cases where collective clinical and corporate decisions are sought and Executive Management team required using their discretion. Overall, the MOH National Referral Policy, as implemented, makes patient referral processes run more efficiently and improve patient access to timely care.

14 REFERENCES

1. Cervantes K, Salgado R, Choi M and Kalter H. 2003 Rapid Assessment of Referral Care Systems: A Guide for Program Managers, United States Agency for International Development, available on line at: http://www.jsi.com/Managed/Docs/Publications/WomensHealth/PNACW615.pdf

2. Department of Reproductive Health and Research (RHR), World Health Organization, Care of mother and bay at the health center: A practical guide, Developing and maintaining a functioning referral system, available on line at: http://www.who.int/reproductive-health / publications / msm_94_2 / care_mother_baby_health_centre.pdf

3. Referral Systems: a summary of key processes to guide health services managers. www.who.int/management/Referralnotes.doc

15 DEFINITIONS

Table 5: Definitions

Referral	a process in which a health worker at a one level of the health system, having insufficient resources (drugs, equipment, skills) to manage a clinical condition, seeks the assistance of a better or differently resourced facility at the same or higher level to assist in, or take over the management of, the client's case.
Initiating facility	the facility that starts the referral process
Outward referral	Communication from the initiating facility of the client conditions and status
Co-morbidities	Multiple illnesses impact on a disease process
Triage	Assessment of urgency of patient management against categories 1-5
Repatriation	Returning pathway to community
Continuum of Care	Seamless patient care management form one facility or specialty to another
Patient Self-Referral	Individual presenting to health facility for care
Best Practice	Based on evidence and lessons from review processes and research to determine what is optimal patient care
Quality Care	MOH quality cycle outlines the essential components of delivering and review best practice in patient care for the people of Vanuatu

16 APPENDIX

APPENDIX 1: SBAR & DISCHARGE SUMMARY

S — Situation

Give a handover of diagnosis / reason for admission	
Under care of Team	
Admitted on (Date)	

Observations immediately prior to transfer of patient :

BP		Pulse		Resps		IV site		Pain score	
Sp02		BSL		Temp		IV Duration		Analgesia Given	

B — Background

Infection status:	
Notifiable Disease	
Other potential infectious disease	
Diarrhoea	☐
Vomiting	☐
Isolation required.	☐

Specify treatment, management & risks of patient:
(e.g. Falls, Cognitive Impairment):

Discussed with :			
Family	☐	Carer escort required	☐
Receiving ward	☐	Family provided with ward Tel #	☐

A — Assessment

Immediate Concerns:

Summarise all current needs:

Level of Escort required:		Frequency of Observations (incl. Neurological) required		Oxygen and suction required	☐

R — Recommendations

Any test / care needs outstanding			
Drug Chart checked.	☐	Care plan in Notes?	☐

Clinician Name		*Signature*		*Date*	

Vanuatu MOH
Discharge Summary

1. Name:

2. Date of Birth

3. Primary Reason for Admission and History of Presenting Illness:

4 Significant Pathology / Radiography

5 Progress Note Summary

6 Discharge Plan / follow up

7 Medications on Discharge

Discharge handover to

Discharge Date

Signature

Appendix 2: Guidance for level of Escort and Equipment

All escorts should ensure basic equipment for warm and comfort as well as telephone for communications.

Table 6: Guidance for level of Escort and Equipment required

Criteria	Minimum Equipment	Level of Escort
Patient is incubated or at risk of requiring ventilation	• Oxygen / Emergency Drugs / fluids • Bag / Valve / mask • Monitoring 02 / BP	Senior Medical officer and Emergency Care Nurse or Intensive Care Paramedic
Patient is being transferred on oxygen of any percentage and / or intravenous medication	• Oxygen • Fluids	Registered Nurse / Paramedic
Antenatal patient in suspect labor or complications related to delivery	• Fluids Delivery Kit	Midwife / OBGYN Specialist
Patient going to another hospital for routine appointment		Family escort

APPENDIX 3: IMPLEMENTATION PLAN

The overall responsibility of the implementation of this policy is the responsibility of the Director General and is delegated to the Director of Hospital and Curative Services. Table 4 outlines an implementation and monitoring plan until 2022.

Table 7: Referral Policy Implementation Plan

Referral Policy Implementation Plan		**2019**	**2020**				**2021**				**2022**			
Milestone and Tasks	**Resposibility**	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
National Adverse Committee establishes a sub committee to review the implementation of the national referral Policy	***DoH & CS***													
Establish Implementation Sub Committee	National Adverse Committee													
Launch and Introduce Referral Policy in Vanuatu	DoH & CS													
Officialy Launch Referral Policy	Implemenation Sub Committee													
Distribute Referral Policy to Provinical Executive Teams	Implemenation Sub Committee													
Conduct training against key standards set out in this policy for staff in health centers and provincial hospitals	***Med Sup and PNO***													
Conduct introduction training for PHC staff in health centers	Provincial Executive Team + PNO													
Conduct introduction training for key Hospital Staff	Medical Super Intendent + PNO													
Conduct Refresher Training on a yearly basis	Provincial Executive Team + PNO													
Ensure application of and adherence to set standards in this policy	***Implemenation Sub Committee***													
Establish Monitoring and Evaluation Framework	Impl. Sub Committee + M&E Officer													
Review Implementation	Implemenation Sub Committee													

APPENDIX 4: OBJECTIVES AND INDICATORS –

Table 8: Objectives and Indicators

#	Objective	Key Performance Indicators	Outputs
1	To develop referral procedures and guidelines for each level of health care delivery	• Number of health facilities implementing the Procedures and Guidelines	• Patient satisfaction surveys. - Reduction avoidable referrals
2	To build the capacity and confidence of health care workers at different levels	• Number of supervisory visits conducted and reports available. • Number of in service training sessions conducted. Number of staff trained. • Number of staff adhering to Policy	• Reduction in referrals • Number of unnecessary referrals. -National standards and norms developed and in use
3	To continuously improve the quality of health care services	• Number of clinical meetings/ seminar conducted -Reports available. -number of attendees. - Number of deviations identified and corrected.	• Clinical management skills improved. • Functional Adverse events r/v
4	To allocate adequate resources appropriately (human) in terms of numbers and skill mix, financial, and equipment	• Number of health facilities with appropriate skill mix. -number of health facilities allocated with resources according to. allocation criteria	• Reduction in unnecessary referrals.
5	To strengthen specialist outreach support services to regional and provincial hospitals and medical officers support visit to health centers and aid posts	• Number of visits conducted and reports available. • Number of patients seen in specialist outreach	• Reduction in referrals of patients/clients satisfaction
6	To develop standard mechanism for coordination and communication between different levels of health care.	• Number of referred patients with SBAR complete	• Well-coordinated referrals

APPENDIX 5: RESOURCE IMPLICATIONS

Table 9: Implementation Resource Implications

#	Action	Resource Allocation	Responsible
1	1.1 Education Sessions with Executive 1.2 Introduction of the policy, procedures and guidelines e.g. Triage	2020 Budget Plan TBA	Managing Contractor - Team Leader and DH&CS
2	2.1 Training of users on policy, procedure and guidelines / forms e.g. SBAR 2.2 Supervisory support to provincial hospitals 2.3 Monitoring of the implementation of referral policy	2020 Budget Plan TBA	Medical Superintendent
3	3.1 Developing additional procedures and clinical guidelines e.g. essential services packages 3.2 Conducting consultative meetings and workshops	2020 Budget plan TBA	Medical Superintendent and ALL clinicians
4	4.1 Conducting summative evaluation (See Monitoring & Evaluation Framework – Table 2 indicators) 4.2 Monitoring of the implementation of procedures and clinical guidelines	2020 Budget plan TBA	Medical Superintendent