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MINISTRY OF HEALTH - ETHIOPIA
የዜጎች ጤና ለሃገር ብልጽግና!
HEALTHIER CITIZENS FOR PROSPEROUS NATION!

National Referral Guideline

Emergency and Critical Care Directorate

October, 2020 G.C

Addis Ababa

ACKNOWLEDGEMENT

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CONTENTS

ACRONYMS

Dr.	Doctor
ECCD	Emergency and critical care Directorate
EMS	Emergency medical services
EMT	Emergency medical technician
HSDP	Health sector development plan
MOH	Ministry of Health
MRN	Medical record Number
O2	0xygen
PHCU	Primary health care unit
PR	Pulse rate
ROT	Referral audit tools
RR	Respiratory rate
SDG	Sustainable development Goal
TO	Temperature
WHO	World Health Organization

Definition of terms

Referral system: - a system that consists of client, expertise and medical equipment transfer between health facilities.

Pre-facility referral:- includes referral to health facility from Community, health post, and self-referral, ambulance referral, community volunteers.

Vertical inter-facility referral:- includes referrals made to higher/ lower level of the health facility

Horizontal inter-facility referral:- Referral made between facilities at equal levels of

Diagonal referral:-when a lower level health facility directly refers patients to a specialized facility without necessarily passing through the hierarchical system

Client transfer:- transfer of some or all the responsibility for the patient's care temporarily or permanently and for a particular purpose, such as investigation, consultation, care or treatment of the patient,

Expertise transfer:- the transfer of given expertise from one facility to other facility for less than three months

Medical Equipment transfer:- Sharing medical equipment and supply between health facilities based on national resource sharing protocol.

Referring facility:- a health service organization that initiates the referral process.

Receiving facility:- a health service organization that receives patients or clients from referring units

Number Referral out:- the total number of the clients who are referred to other facilities

Number Referral in:- the total number of the clients who are referred to the facility

Referral completed:- the total number of the patients who are referred and the feedback sent back to referring facility

Liaison and referral office:- an office that coordinates and oversees the whole referral network in health facility

CHAPTER 1: INTRODUCTION

1.1. Background

According to the world health organization (WHO) declaration the highest achievable standard of health is a fundamental human right; pivotal to this right, the delivery of health care in hierarchical health system in the existence of a well-functioning referral system that apportion for continuity of care across different tiers of care. In addition 1978`s Alma Ata declaration underscore and consider community participation, and functional referral systems as prerequisites of the health system. Likewise, the majority of health systems in the world adhere to hierarchical that begin with primary care, secondary care facilities up to highest level of care that include tertiary -level care that provide specialty service.

In Ethiopia, there is a three-tier health service delivery that aims at improving the quality and accessibility of health service by means of maintaining continuum of care though the entire level. Hence, to achieve this effective referral system was in a place for which a national referral guideline was developed and implemented since 2013 that helped to organize hospitals' liaison (Bed management, Admission and discharge) and referral services. These have already contributed in decrease in mortality and morbidity that arises from emergency medical situation, helped to maintain continuum of care from PHU to tertiary hospitals.

Despite the impressive progress that are made for the last two decade, still the liaison and referral systems across the various levels of care are not strong enough that influences the overall accomplishment of the health system and contributes to poor health outcomes of emergency patients. According to different assessment conducted by MOH the following challenges were identified; poor referral documentation, weak feedback mechanism, no operational guideline for referral catchment, very weak communication among health care facilities, cost effective and cost saving ways like clinical expert outreach service (expert referral) and medical equipment sharing mechanisms, and uneven distribution of number of patients' between health facilities.

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Consequently a 2013's referral guideline is revised to provide comprehensive information on national referral system and give direction on current and new standards; recommendations and day-today operation of health facilitate to develop effective referral system that responds to health need of the community, and possibly help to solve the stated problems.

Referral system composed of the client transfer from the pre-facility to inter-facility patient's referrals which aimed to maintain continuum of care, expert-transfer which is aimed to capacitate the lower level health facilities and minimize the number of referral out and the equipment transfer that aimed to enhance resource utilization and decrease number of referral out due to medical equipment. Under this guideline the client referral will be discussed thoroughly as MOH has already developed separate expert and equipment transfer guideline.

1.2. Situational Analysis for Referral Services

In the last two decades Ethiopia has invested in health sectors which have resulted in substantial gain in improving the health condition of its population. From 2005 to 2016 the life expectancy has increased from 56.8 to 65.5 years. A consecutive DHS survey showed significant decrement in neonatal mortality, and maternal mortality. More over the country has made impressive progress in emergency and critical care. More than 5000 numbers of basic ambulances were provided for rural communities, emergency and critical care professionals were trained and deployed, and ICUs were established in different hospitals.

One of the last decade breakthroughs in Ethiopian health systems that contributed for the stated achievements is the establishment of liaison and referral offices at all health facilities, which enables the country's three tier level health services systems to easily transfer patients from lower to higher level health facilities, and vice versa. The referral services were supported with national referral guidelines, standardized referral format and training of referral and liaison officers for the last few years.

Though the stated achievement was promising there are still gaps in the country's referral system which arise due to different reasons. Today only 28% of the parties are referred with the formal referral format, 70% of referral bypasses the level of the facility, and 39% of the referral is made without stating even the vital sign of the patients. Most importantly only 10% of patients are

referred back to lower level hospitals and much less referral are made with communication, which is very traditional. In addition the referral service documentation, monitoring and evaluation are poor even compared to other services within the health facilities.

This all has contributed to the high emergency and ICU mortality in the country, low patient satisfaction in health services, and posed huge economic burden to patients and the health facilities. Seeing crowded emergencies in tertiary hospitals due to unnecessary referral from the lower facility, and self-referral are becoming common.

Today Emergency and critical care is committed to solve problems that are related with referral, and ensure health facilities have even distribution of patients thus developing national emergency and critical road maps, revised referral guideline and developing a referral software to support the referral services with technology. More over the directorate is striving to capacitate the health facilities to decrease total referral out and repeated referral for the same patient.

1.3.Rationale for revision of the Referral Guideline

The government of Ethiopia has committed itself to the achievement of a sustainable development goal which stated one of its goals as "Ensure healthy lives and promote well-being for all at all ages with nine targets. Under goal 3 target 4 and 6, it is planned to decrease the global death by halve by 2020 from non-communicable disease, and road traffic accidents respectively.

To achieve these goals resilient and quality emergency care and patient's transfer and easy communications between health services providers are crucial and irreplaceable. Beyond the SDGs, the Ethiopian government strongly believes that emergency care and strong functional referral system are one of the key strategies to improving community health and bringing about development. Hence, Cognizant of the need emergency care in the country to ensure standardized, high-quality, client-centered, broad-reaching emergency care services that recognize the various levels of care, from the PHCU to the central referral hospitals; Understanding the importance and relevance of the lower level health facility utilization, Being aware of the fact that the 2013 referral guideline is out of date with current developments and the need to address new targets and directions; and to provide comprehensive information on

national referral system and give direction on current standards; recommendations and day-today operation of health facilitate to develop effective referral system that responds to health need of the community this referral guideline has been revised with close consideration of and reference to the relevant policies, strategies, guidelines, and legal documents. The guideline focuses on the client, expert and medical equipment transfer between health facilities.

1.4.Policy context

Ethiopian has given great emphasis for the patient's referral in its health policy, as it has clearly indicated in 1993 transitional government health policy "Referral System shall be developed by: Optimizing utilization of health care facilities at all levels, improving accessibility of care according to need, assuring continuity and improved quality of care at all levels, rationalizing costs for health care seekers and providers for optimal utilization of health care facilities at all levels and strengthening the communication within the healthcare system.

Following the policy the country had been developing a consecutive health sector development plan (HSDP I to IV) which was implemented from 1997/8-2004/209/10. The latest and under implementation HSDP-IV was developed in 2010/11 to run through 2010/11 – 2014/15. In this fourth HSDP it is clearly planned to improve accessibility of health services of all kinds, including emergency and referral services, and thereby ensure service utilization. Therefore e the health center is meant to serve as a referral center for healthy posts and provide health care that will not be available in health posts and a primary hospital serve as a referral centre for HCs under its catchment areas. The Third tier of care center Referral and specialized hospitals are meant for the handling of more complicated and sophisticated health care, including the clinical management of non-communicable diseases. The plan has put its target on 2010 to increase the proportion of referred patients completing referral successfully (from beginning to feedback) to 80%.

The recommendation of HSDP IV comes from the three-tier health system of the country, which put the PHCU at the bottom of the tier and tertiary and referral Hospital at the top of it. Following this Emergency and critical care has developed a national referral guideline by 2013 which allowed ECCD to achieve tremendously in referral and liaison office services.

Now the country is revising its 25years serving health policy and the draft is released for the public comments. The policy has given stress on functional a referral and strong communication between health facilities as usual. Therefore it is too important aligning our referral guideline with national HSDP's and policy to increase the lower level health facility utilization and easy communication of all levels of health service providers, and smooth transfer of patients between service providers.

1.5.Objective of the guideline

This guideline is meant to guide the establishment and effective management of referral system with linkage across all the level of care in Ethiopia, specifically it is developed to enhance the use of services at lower levels of the health care system, and expand the system's ability to transfer clients, and experts and equipment between different levels of the health care system. The guideline describes what referral services Ethiopia should look like and the requirement and process of the referral services. It gives guidance for health professionals on how to refer a patients, and helps health facilities to organize referral services and patients flows in the facility. . Moreover it puts the role and responsibility of stakeholder in each level of the services provision, and helps health sectors leader in monitoring and evaluation of the referral services. The guideline is applicable in all Ethiopian hospitals, but the regional health bureau can adapt this guideline to their regional state

Chapter 2 - Referral system in Ethiopia

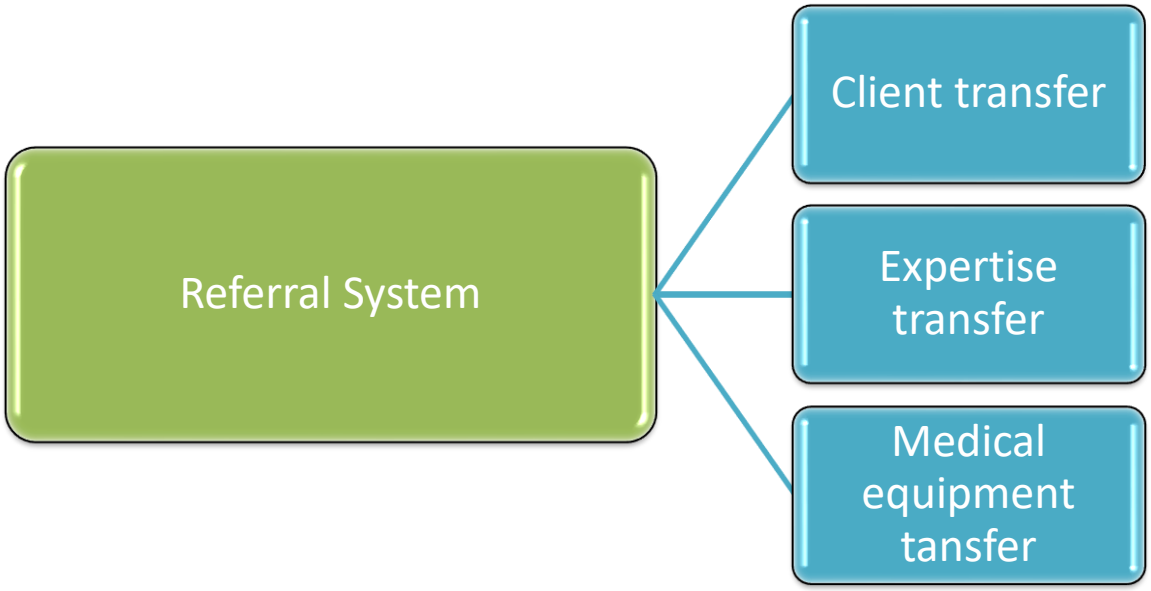
2.1. Referral flow

2.2. The Framework for Referral system

A referral system is a system that consists of client, expertise and medical equipment transfer between health facilities. It is a two way process which helps to ensure continuum of care to patients in Ethiopian's three tier health system, from community to PHCU then tertiary hospital as shown in Figure 1 below.

The clients transfer of the referral system consist of receiving clients from the pre-facility services which is called Pre-facility to facility referrals, and inter-facility referrals which consists of referral of clients between health facilities.

Fig 1.Framework for health referral service



2.2.1. Clients transfer

A client transfer is a transfer of some or all the responsibility for the patient's care temporarily or permanently and for a particular purpose, such as investigation, consultation, care or treatment of the patient to other health facility or department/disciple. These could be internal client transfer if it is between the department within the facility or External if it is between two different health facilities or Facility to Home-Base/pre-facility Care clients transfer.

An internal client transfer within the facility should depends on the each hospital internally agreed rule and regulation or SOP. There for all hospitals need to develop SOP for internal patients transfer and format to be filled during patients transfer.

The external clients transfer could be classified as Pre-facility to facility, Facility to facility and Facility to Home.

2.2.1.1 Pre-facility to facility clients transfer

A pre-facility Clients transfer is a transfer of emergency patients from home, incidents site, and ambulance to any level of health facilities. During pre-facility to facility the following points should be considered

1. All pre-facility referral should be based on national pre-facility services guideline
2. All health facilities must accept all Emergency patients who are referred to them by pre-facility service providers
3. Pre-hospital medical emergency forms shall be completed by the Ambulance service crew and signed by the liaison officer at the receiving facility.
4. Where referral to another institution is required, initial care must be provided to the patient.
5. In the case of referral to another facility, continuous medical care should be ensured in the ambulance

2.2.1.2. Facility to Facility Clients transfer

Facility to Facility Clients transfer is a referrals between health facilities aimed to transfer of some or all the responsibility for the patient's care temporarily or permanently and for a particular purpose, such as investigation, consultation, care or treatment of the patient to other health facilities

2.2.1.2.1. Essential Elements of Facility to Facility Clients transfer

For optimal effectiveness of Facility to Facility Clients transfer operation the following seven essential elements need to be in a place

- Liaison and referral office
- Referral catchments
- Different Format (referral format, Referral in, and referral out registry, feedback format, No letter)
- Services directory of a defined catchment area
- Infrastructure (equipped and functional ambulance with a driver, dedicated phone line, computer with printers, internet services, and photo copy machine).
- Referral network agreement
- Web based referral service

2.2.1.3. Reasons for Facility to Facility Clients transfer

- Patient needs an expert advice as determined by the attending health professional
- Technical examination is required that is not available at the referring facility
- Technical intervention that is beyond the capabilities of the facility is required
- Medico-legal requests not within the capability of the health facility concerned should immediately be referred to the appropriate level
- When a referring facility cannot no more accept patients due to shortage of beds and unavailability of professionals

2.2.1.4. What should be fulfilled during an Facility to Facility Clients transfer

- Once a client transfer is decided a patient should be immediately linked with to liaison and referral office
- All clients should be told why, when and where to be transferred
- All emergency and critical patients should be stabilized and resuscitated before transferring
- All emergency patients should be transferred with equipped ambulance escorted with health professionals
- A referral form should be filled and signed by referring health professionals with his/her telephone number in legible writing and stamped
- Relevant laboratory and imaging result are attached to the referral format
- All referral should be communicated to receiving facilities though telephone, web based referral or fax providing detailed identification and situation of the patients to be sure that bed and required care and services are available at receiving health facility
- In addition to this before referring a patient a liaison officer should check the following things
    - Register the patient on referral register (sample on annex)
    - A receiving facility liaison officer should inform the emergency and inpatient case teams to be ready for the management of the patient.
    - Refereeing facility's liaison and referral should Follow the condition of patients on the way by telephone
    - Refereeing facility's liaison and referral Ensure the patient arrived at receiving facility

- Arrival to receiving facility of the patients should be confirmed by referring liaison officer

- If the liaison can't find the service to refer the patient, the patient should stay in the facility with necessary care until the liaison gates the needed service
- The facility with the services are obliged to receive an emergency patients from the lower level health facility (no administrative problems like beds can taken as excuse not receive an emergency patients
- When there is a need to transfer a clients to a lower level health facilities it depending on:
  - The condition of the patient
  - The capacity of the lower level health facility

2.3. None emergency patients referral

- When a facility calls to transfer of a non-emergency case that needs admission the liaison office at a receiving facility should
- Check the appropriateness of the referral with respect to diagnosis and need for immediate intervention
- The receiving facility should arrange elective admission dates and inform the patient through the referring liaison officer.
- A receiving facility liaison should keep the list of patients referred with their address if possible mobile number
- A liaison should present the elective admission list to the inpatient case team on a regular basis preferably on daily bases.
- The patients will be receive on the date appointed
- The priority should be given for those patients whose medical condition need immediate intervention

2.4. Facility to Home-Base Care clients transfer

In case of those clients at the end of life who need home based care or palliative care, the following points should be considered before transferring a patients from health facilities to home based care.

1. It is only by senior specialist or under his/her consultation and authorization that the decision to transfer a patients to home based care is made
2. It is only by senior specialist who determine life expectancy of the patients in the case of terminal illness
3. The patients and family members should be told life expectance and the treatment out come and need to transfer a patients from health facility to home based care
4. The Health facility should be certain that the patients could get proper care at home, at least, t the patient can get pain and other symptoms management
5. The patients can at least easily Visits Health center in case there is need
6. Family should be told what care should be given to patient at home
7. The family and the patient should be in agreement on the transfer of the patients

2.4.1. Criteria to transfer for Home based Care

1. Any person with terminal illness and estimated life expectancy is below six months depending on the course of the disease
2. The treatment (curative surgery, and medications) is no longer effective
3. If the curative treatment not available in the country and the patients cannot afford to be transferred to abroad

2.5. International Clients transfer (Abroad referral)

Abroad referral is a transfer of patients outside/to Ethiopia from/ to other country for sole purpose of receiving health care. This Clients transfer does not include those patients who travel to other country without Ethiopian Hospital referral, or those who were treated in foreign country while living in or visiting the stated country.

2.5.1. Issue related to abroad referral

1. Only Ethiopian tertiary Hospitals can refer a patients outside the country
2. The medical board of the referring facility should confirm necessity of the referral outside the country
3. The patient should be clearly told reason for referral, and expected treatment outcome

4. The hospitals for which the referral is going to be made should be registered and offer only services legally approved by hosting country and verified by Ethiopian MOH
5. There should be legal agreement, approved by MOH-MSGD, between two hospitals to transfer a patient to each other
6. If a patient needs to be referred to any other hospitals that has no agreement with Ethiopian hospital the referral is allowed with all responsibility to be y their own
7. All referral abroad should pass though MOH to be confirmed and registered

2.5.2. Expectations from Foreign country Hospitals

1. The foreign hospital should send confirmation letter to MOH weather it is licensed or not, along with its service directory and cost of each services though Ethiopian Embassy or its own country Embassy in Ethiopia.
2. The Hospital should have agent or legal representative in Ethiopia, whom held accountable if the Hospital did not provide the promised services with sated standards.
3. The Hospital's agent/ legal representative should sign agreement with MOH representing Hospital
4. The Hospitals should be willing to explain and disclose patients record to MOH, if it is requested
5. He hospital should be willing to cooperate and get in to agreement to work with Ethiopian Hospital in research and development of medicine and patients transfer
6. The Hospital should be willing to send referral feedback to Ethiopian hospital though the hospital that is assigned by MOH

2.5.3. Reason for abroad referral

1. Treatments that is not available in Ethiopia such as injection of stem cell, transplant,
2. If diagnostic tools not available in Ethiopia
3. Too long waiting list, more than 2months, for certain procedure in Ethiopia
4. If three or more medical experts in Ethiopian believe that treatment outside the country could significantly affect the outcome of patients with respect to loss of live and function.
5. If there is no experts to treat the patients in Ethiopia

2.6. Expertise transfer

There are some instances when it may be more efficient for transfer of given expertise or services to health facilities. Experts can be transferred between health facilities for the following reason based on the facilities agreements

- **For non-emergency specialist services**: - Required expertise in this case could be drawn down either on a regular basis, or on an ad hoc basis if feasible.
- **During emergency responses**:- when there is disaster or emergency that need more health professionals, an experts can be drawn down from other health facilities immediately with the request of the health facilities if in the catchment area or with the request of regional and national disaster team
- **During a company**: - an expert can be transferred when there is a campaign to conduct or provide health services for a large number of communities in need.
- **For knowledge sharing**: - an expert can be transferred to another facility in a request if there is a need for job training or knowledge transfer.
- **To initiate new services**:- whenever there is a need to initiate new services in Health facility health professionals can be transferred to other facilities to help in initiation and guide to new services provision and management.

2.7. Medical equipment transfer

Medical equipment transfer between health facilities is a component of the referral system for which MOH has developed a separate resource sharing protocol. Therefore health facilities within the same referral catchment are required to share resources based on the protocols and other legal documents.

Chapter 3: General principles for referrals

3.1.Principle of Referral System

1. **Clear Referral Criteria :- In all health facility, those clinical criteria that is used to refer a patients should be developed in line with a national referral guideline and communicated with all health professionals and other concerned body**
2. **Equity of care and access:- A referral service should be given for all clients equally, no decision should be based on non-clinical need of patients**
3. **Referral is a medical decision: - Referral is made based on the clinical need of patients by senior health professionals in non –emergency cases and if seniors are not available, other health professional can initiate the referral.**

3.2.Referral process (chart will be interned)

3.3.Communication and transportation

- All emergency referral transportation should be by ambulance and for free
- Road traffic accident patients transportation is covered by third party insurance
- All health facility should equip their Ambulance with basic life saving medical equipment like…O2, airway set, neonatal towel, delivery set, PEP, Fluids, cannula, Plaster, Gauze, alcohol, and glove
- All health facilities are obliged to take Emergency patients to the next referral center with equipped ambulance escorted with health professional
- A referring Health professionals decide the health professionals to be escorted with emergency patients
- Accompanying health professionals should be dressed professionally and geared with personal protective equipment
- Accompanying health professionals should be besides the patient

- If the clinical condition of the patients need two or more health professionals (as intubated patients, or patients with additional medical problems) a referring doctor and a medical director shall be decided as a team.
- The patients should be handled to Liaison officers in receiving Hospital

3.2. Feedback to Clients transfer

- Receiving facility should send Feedback to the referring facility using national format
- The attending health professionals at the receiving facility must clearly specify on the feedback form, details of ongoing management or further therapy required.
- The attending health professional at the receiving facility possibly refers patients back to the referring facility for continuation of management
- The referring facility liaison office must register the feed backs and report to health facilities management

3.3.Referral catchment

Referral Catchment is a group of health facilities that, in the aggregate, provides comprehensive care and prevention services to meet the needs of patients, within a defined geographic area.

3.3.1. Why do we need referral catchment?

- Referral catchment is developed referral has the following importance
- It reduces patient bypasses and increases utilization of the primary health care unit
- Reduces the burden of tertiary hospitals and allow them to focus on specialty services
- Encourage service accountability (the referring and receiving ends can be identified easily)
- Patients clearly know where to go during referral
- Avoids unnecessary wastages of patient resources
- Information flow between facilities during referral will be easier
- Makes simpler to make transportation arrangements
- Makes easier for regional/zonal managers to monitor and evaluate the referral system. Referral process indicators

3.3.2. Referral catchment organization/level

- **First level referral Catchment**:-included health posts, health centers and Primary Hospitals and lead by the primary Hospital and co-lead by best performing health center
- **Second level catchment**:- included general and district hospitals and lead Health centers lead by the General Hospital, and co-lead by best performing primary Hospital
- **Third level catchment**:- includes primary, General hospital, and tertiary hospitals and lead by tertiary Hospital and Co-lead by best performing general hospital

3.3.3. How catchment Operates

- All catchment has a lead health facility which its leader serves as a chairman
- Catchment member health facility should sign referral network agreement for each other
- Referral catchment forum should be conducted twice a year
- A lead Hospital conducts referral audit for its catchment once a year using national audit tools
- A best performing facility will co-chair the catchment with the lead hospital
- The catchments meeting summary report should be sent to the appropriate body

CHAPTER 4: ROLE AND RESPONSIBILITY

4.1. Ministry of Health

- Initiates legislation; develops policy and SOPs for the implementation of the referral system
- Sets standards for the health facilities across the new tier system
- Develops the standards for resources to be available at health facilities
- Capacity building of the referral system
- Monitors and coordinates referral systems at national level
- Revises and updates the referral system as appropriate
- Works with regions for the preparation of national directory of health services

4.2.Regional health bureau

- Ensure that health facilities conform to the standards set by the regulatory agency
- Based on the national health tier system, prepare regional service map and service directory and ensures population size and distance are taken in to consideration
- Regions will develop and implement referral standard operating procedures
- Regions create mechanisms to improve community awareness of the referral system through community communications channels, use of health extension workers
- Ensure emergency medical services are given without any restriction
- Design mechanisms for coordination of referral activities within the region and feedback system
- Receive, compile, and analyze data and gives feedback to facilities to improve the referral system
- Hold regular meetings in the region to analyze reports ,hears referral complaints, distributes guidelines, and increases public awareness

4.3.Health facility

- Ensures liaison and referral office is staffed, equipped and providing service 24hours/7 days

- Assigns referral coordinator with clear roles and responsibilities
- Ensure health professionals are aware of referral system and guide line
- Performs a situation analysis regarding the process of referral in the facility
- Conduct regular referral catchment forums with the collaboration of other facilities in the catchment.
- Ensure referral catchments in defined, services directory updated regularly,
- Ensures proper recording of all referral activities, bed management, feedback system, and reporting are in a place
- Ensure the facility's ambulance is equipped, and functioning according to this standard
- Provides continuing education about the referral process to staff and the community
- Ensures patients are referred by appropriate most senior health professionals in the facility
- Ensures that all prescheduled referrals are attended without undue delay
- Develop and execute quality improvement project on referral services
- Conduct clients satisfaction surveys one a year.
- Collect data and send referral report to concerned body

4.4.Liaisons and referral office

- Coordinates the overall referral activities, ambulance services, bed management and a regular patients appointments within the health facility
- Records and reports the referral activities, bed senses , and ambulance services to facility management
- Compiles, analyzes, and interprets referral data to improve the referral service
- Involvement in the quality assurance programs of the referral system by participating in referral forum within and outside the health facility
- Update catchments, and services directory every three months
- Communicate referring and receiving facility
- Ensure emergency patients are escorted with health professionals
- Send and receive all referral in and out based on the service directory and availability of patients bed
- Ensure feedback is sent to referring facility

- Receive feedback from receiving facility and took corrective action/ report to concerned body
- Participate in referral forum, and other review meeting on referral

3.4.3.5 Health professional

- Resuscitate and stabilize any patients before referral is made
- Inform when, where, and why referral is made to the client and Communicate with the client's family
- Decide the health professionals to be escorted with emergency patients
- Properly Fill a referral format in legible writing
- Write name, address and sign the referral format
- Ensure a transferred patients has arrived to receiving facilities with liaison office
- Responds promptly to consultation requests
- Fill the referral feedback format and report Reports in detail all pertinent findings and recommendations to the referring health facility
- Does not attempt by word or deed to undermine the role of the referring health worker
- All investigations and documents attached with the referral form from the referring facility should be considered to protect patients from unnecessary cost

CHAPTER 5: MONITORING AND EVALUATION

Referral systems should be evaluated at regular intervals and at minimum, annual evaluations should be conducted regionally/nationally level. It is important to know whether the referral service is making progress towards its objective. Monitoring and evaluation helps the health facility to understand what they are working well, what is suboptimal and where their gaps are. It facilitates the health facility leader's decision making and whether any adjustments are required. It will also determine whether various components of the referral guideline have been successfully integrated into health facility planning, and action, as well as increase accountability of stakeholder.

At each level of health service delivery (health center to tertiary hospital) and administrative level (Woreda to Regional health Bureau) different indictors could be used to facilitate and monitor implementation against annual target for referral

5.1.Component of referral system monitoring and evaluation

- Regular Quarterly referral audit
- Quarterly referral report using referral reporting format
- Bi annual catchment meeting between health facilities within the same catchment
- Regional and national review meeting which is health annually

Different indicators could be used to assess the process, outcome and impact of the referral service, some of the indicators which could be used are listed and annexed but the following will be the targets and/or indicators that will be used to measure progress and impact on referral services at regional and national level.

- Referral Rate
- Emergency referral rate
- Percent of feedback sent
- Rate of Referral out with communication

5.2.Selected Referral indicators

S.N	Indicators	Nominators	Denominator	Use	Reporting period
	Referral in rate (RIR)	Number referral in (cold and emergency)	Total number of outpatient visits (include emergency and cold)	> 70% lower facility utilization is very good <30% self referral is high need to analyze why clients don't use low level health facility	Quarterly
	Referral out rate (ROR)	Number referral out (cold and emergency)	Total number of outpatient visits (include emergency and cold)	>20% analyze top five reason for referral and consider to open the services <10% conduct audit on professionals scope of practice	Quarterly
	Emergency referral in rate (ERI)	number of emergency referral in	Total Number emergency visit	The same to above	Quarterly
	Emergency referral out rate (ERO)	Number of emergency out	Total Number emergency visit	The same but consider to improve emergency services	Quarterly
	Rate of referral out with communication (RIC)	Number of referral out with communication	Total Number referral out (cold and emergency)	100% excellent performance for liaison and referral office <80% low, consider referral based QI	Quarterly
	Rate of referral in with communication(ROC)	Number referral in with communication	Total Number referral in (cold and emergency)	100% excellent performance for liaison and referral office <80% low, consider	Quarterly

				referral based QI	
	Rate of emergency referral in with ambulance (RIAM)	Number emergency referral in with ambulance	Total number of emergency referral in	100% excellent keep it up, and support the lower facility <80% low considers evaluating why?	Quarterly
	Percent of feedback sent (PFS)	Total Number feedback sent	Total Number referral in (cold and emergency)	100% excellent performance for liaison and referral office <80% low, consider referral based QI	Quarterly
	Percent of feedback received (PFR)	Total Number feedback received	Total Number referral out (cold and emergency)	100% excellent performance for liaison and referral office <80% low, consider referral based QI	Quarterly

ANNEX

Annex I: Register of Referrals OUT

S.N	Date	Name	MRN NO	Reason for referral	Emergency/non emergency		Sent with ambulance		Communicated		Feedback received	
					Y	N	Y	N	Y	N	Y	N
Sheet summery												

Annex II: Register of Referrals IN

S.N	Date	Name	MRN NO	Reason for referral	Patients condition				Appropriate referral		Emergency/non emergency		Come by ambulance		Communicated		Feedback sent	
					Critical	Emergency	Stable	Dead	Y	N	Y	N	Y	N	Y	N	Y	N

Sheet summery																		

Annex III: Liaison and referral Office Report

Quarter_____From_____to_____

Name of Health facility _____

S.N	Nominators	Number	
1.	Total number total attendant of the hospital (Emergency and cold)		
2.	Total number emergency visit		
3.	Total number referral in		
4.	Total number referral out		
5.	Total Number of Emergency referral in		
6.	Total number of Emergency referral out		
7.	Total number of Referral out with communication		
8.	Total number Referral in with communication		
9.	Total number of emergency referral in with ambulance		
10.	Total number of feedback sent		
11.	Total number of feedback received		
12.	Total number of referral in arrived dead		
13.			

Name of the liaison office _____Sign _____Date_____

Annex IV: Ministry of health National Referral form

National Patients referral Format
Referring Health Facility Name of facility _____Liaison office telephone_____
Receiving Health Facility Name of facility _____Liaison office telephone_____
Patients Identification Name_____ Age _____Sex _____
Chief Complaints of the patient_____
Condition of the pities (circle one) Critical Emergency stable
History of present illness _____
Finding BP _____PR _____RR _____Body T^0_____O_2saturation_____ P/E _____
Diagnosis _____
Treatment given _____
Reason For Referral _____
Recommended Health Professions to escort the patients(state the profession not name) _____
Referring Health professional Name_____ Cell phone _____Sign_____
Escorting Health professional Name _____Cell phone _____
Referring liaison officer _____Phone _____Sign_____

Annex V: Ministry of health national Referral feedback Form

National Patients referral feedback Format
Referring Health Facility Name of facility _____Liaison office telephone_____
Receiving Health Facility Name of facility _____Liaison office telephone_____
Patients Identification Name_____ Age _____Sex
Condition of patients on arrival(circle one) Critical Emergency Stable Dead (No any sign of life)
Diagnosis _____ Circle one____ (**the Same**) or (**Different**) from the referring facility (check the referral format)
Treatment
Comment of receiving health professional
Referring Health professional (Fill from referral format) Name_____ Cell phone _____Sign_____
Receiving liaison officer _____Phone _____Sign_____
Commenting Health professional Name_____ Cell phone _____Sign_____

Annex VI: Referral catchment agreement form (Amharic)

በጤና ሚኒስቴር የ ጤና ተቋማት የ ህመማን ቅብብሎሽ የ መግባቢያ ሰነ ድ

የ ጤና ተቋማትስ ምና አድራሻ ›

መግቢያ

የ ተገ ልጋዩ ንፍላጎ ትማሳ ረትባ ደረገ ሜል ኩየ ህክ ምና አገ ልግሎትቀና ነ ትእና የ ታካ ሚውን ደህን ነ ት ባረ ጋገ ጠሜል ኩየ ጤና አገ ልግሎቱን ጥራትለ ማሻ ሻል ከላ ይስ ማቸውየ ተጠቀሱየ ጤና ተቋማትይህ ንየ ህ መማን ቅብብሎሽ የ መግባ ብያ ሰነ ድየ ተፈራረ ምሳ ውየ ህ መማን ቅብብሎሽ ስር ዓቱበ ሀገ ር አቀፍየ ህ መማ ንቅብብሎሽ መመሪ ያእና ውል ማሳ ረትእ ንዲሟ ሉእና ተገ ልጋዩ በህ መማን ቅብብሎሽ ላይየ ተሻ ለሙ ተማመ ንእ ንዲኖ ረውለ ማስ ቻልነ ው ፡

በዚህመማሳ ረትበ ሀገ ር አቀፍየ ህ መማን ቅብብሎሽ መመሪ ያ ማሳ ረትእ ናየ መግባ ቢያ ሰነ ድማሳ ረትየ ህ መማን ቅብብሎሽ አገ ልግሎትለ ማስ ጠት ተስ ማምተ ን በስ ራሃ ላፍዎ ቻች ን በ ኩል ውል ገ ብተና ል፡ ፡

የ ዚህ የ ህ መማን ቅብብሎሽ የ መግባ ቢያ ሰነ ድዋና ዓላ ማ ታካ ሚኒ ኪእና ተቀባ ይየ ጤና ተቋማት ማካ ከል የ ጋራመግባ ባት ላይበ ተደረ ሱእና በ ሀገ ር አቀፍደረ ጃየ ተቀማጩ ን የ ህ መማን ቅብብሎሽ ስር ዓቱን መ ሰረ ትያ ደረ ጉአገ ልግሎትለ ህ መማን እነ ዲሰ ጡማ ቻልሲሆን በ ህ መማን ቅብብሎሽ አገ ልግሎት ላይበ ሚ ከሰ ቱአ ለመግባ ባቶች ተቀር ፈውየ ታካ ሚኣ ንግል ትበ ማስ ቀረ ት፣ በ ጤና ባለ ሙያ ውእና በ ተቋማት ቸልተ ኛነ ትበ ሚፈ ር ሱአ ላስ ፈላጊ ጉዳ ቶች ላይተጠያ ቂነ ትለ ማስ ፈን ነ ው ፡

ይህ የ መግባ ቢያ ሰነ ድበ ጤና ተቋማት የ ሚሳ ጡአ ገ ልግሎቶች ታካ ሚውበ ተገ ቢውሜል ኩእ ን ዲጠቀ ምሞ ሚያ ስች ልእና በ ሁለ ቱተቋማት ማካ ከል ግብረ አበ ር ነ ትን የ ሚያ ጠና ክር ፣ እነ ዲሁምስ ለ ታካ ሚሞ ቻቸውበ ሰ ዓቱተግ ባ ቦ ትሚፈጸ ምእ ነ ዲች ሉያ ስች ላል፡ ፡

ትርጉም

ታካ ሚኒ ኪተቋም -
በ ተለ ያዩ ምክ ን ያ ቶች አገ ልግሎትበ ሌላ ተቋ ምታካ ሞእ ን ድያ ገ ኝ ታካ ሚውን የ ሜል ክ ተቋ ም(Referring institution)

ተቀባ ይተቋም - በ ተለ ያዩ ዩ ምክ ን ያ ቶች ታካ ሚሞ ወች የ ተላ ከለ ትተቋ ም(receiving institution)

የ ህ መማን ቅብብሎሽ መግባ ቢያ ሰነ ድግብ

1. ለታካሚውችአመቺ፣ በሰዓቱ፣ ጥራቱንየጠበቀ፣ ህመማንንሚዕከልያደረገየህመማንቅብብሎ
   ሽአግልግሎትለሁሉምታካሚእዲሰጥማስቻል፡ ፡
2. የህመማንቅብብሎሽአግልግሎትበሚሰጡሠራተቋማትመካከልግብረአበርነት፣ ተግባቦት፣
   የአገልግሎትቅንጅታዊእናቀጣይነትያለውየህክምናአገልግሎትማስጠትማስቻል
3. በህመማንቅብብሎሽአገልግሎትላይጡፍማገንኙነትእናየህመማንተሳትፎማሳደግ
4. በጡፍተቋማትመካከልሀገርአቀፍየህመማንቅብብሎሽማሻረትባደረገሜልኩየመተገገዝእና
   የባለሙያተውሰንለማከናከር

የካችማንትአባላትግደታ

1. ወቅታዊየተቋማትአገልግሎትመጨልማዘጋጀትለሁሉምአባላትየማስጠት
2. የተቋማትየህመማንቅብብሎሽአድትበሠሰትወራትማስራት
3. በካችማንቱስብሰባላይየተቋሙላፍእናላይዘንእናሪፈራልአፍስአሰተባበርማኘት
4. ለካችማንትስብሰባየስድስትወር ርፖርትማቅረብ
5. በካችማንቱአባላትየምሰጠትንአስተያቶችተቀብሎማሳተካከያድረግ
6. ለካችማንቱአባላትለልምድልውውጥፍቃደኛመሆን

ሁሉምየጡፍተቋማትሙሟላትያለባቸውጉዳዮች

1. የህመማንቅብብሎሽእናላይዘንቢሮሚደራጀትእናአስፈላጊውንግባዓትሙሟላት
   (ስልክ፣ኮምፒዩተር፣ኢንተርኔት፣የህመማንቅብብሎሽሁሉንምቅጾች..)
2. የህመማንቅብብሎሽእናላይዘንአፈሰርመመጀብእናየስራድርሻማሳወቅ፤ ማብቃትእናመደገ
   ፍ
3. ሁሉምተቋማትየሚሳጭውንአገልግሎቶችወቅታዊዝርዝርማዘጋጀትእናለሁሉምየካችማንቱ
   የጡፍተቋማትማሳወቅ
4. በህመማንቅብብሎሽፎርምላይመማኘት፣ለፎረማአባላትሪፖርትየማቅረብእናለሚሱጥያቄ
   ዎችመልስማስጠት
5. የህመማንቅብብሎሹሀገርአቀፍየህመማንቅብብሎሽመመሪያንየተከተለመሆኑንሚረጋገጥ
6. በህመማንቅብብሎሹሚብውስጥላሉተቋማትመፃወእገዛስያስፈልጋቸውብህመማን
7. ቅብብሎሽመመሪያማሻረትእገዛማድረግ

የህመማንላኪተቋምኃላፊነት

1. የሚላኩሁሉምታካምሞችበተቋማቱላይዘንአፊስበኩልበተግባቦትመሆንአለበት
2. ዌብቤዝድየህመማንቅብብሎሽበሚሰራበትቦታበስልክተደውሎማሳወቅ

3. ተቀባዩ ተቋምከልክየ ሚያነ ሳከሆነ ለተቀባዩ ተቋምየ ስራታላፊዎችአልያምተቋማዚህጉዳ ይለወከለውአካልማሳወቅ
4. የ ተቀባይየ ስራሃላፍዎችማንኛትካለተቻለየ ላኪውተቋምከህመማን ማሳተላለፍያቅፅበተጨ ሚያለተግባቦትታካሚውለምንእንደተላከበድብዳቤገልፆለተቀባዩየ ጤፍ ተቋምማላክአለ በት (ግዜእንዳይወስድደብዳቤዉበፎርምተዘጋድቶመቀማከአለበት)
5. ታካሚውብላኪውሆስፒታልሲገለገልየ ተሰሩየ ላቦራቶሪውጤቶችንጨምሮየ ህመማን ማስተላለ ፊያፎርምተሟልቶ፣ በላኪውህኪምተፈርሞ(ማሉስመተጽፎ) መላክአለበት
6. የ ህመማን ቅብብሎሽስርዓቱንእናአገልግሎቱንትንተናእናምር ሚሩበየ ሶስትወሩማሳራትለ ካችማትፎረምመቅረብይኖርበታል

የ ላኪውባለሞያእና ታካሚውን ይዞየ ሚደውባለሞያታላፊነ ት

ላኪውባለሞያ

1. የ ታካሚሞክተላለፊያቅጽበሚ በብሜልኩመላትአለበት
2. ለ ታካሚውለምነወደሌላተቋምእንደሚያስተላልፉትማክረዳትአለበት
3. ወደተቀባዩ ተቋምአብሮትየ ሚደውን ባለሞያእናታላፊነ ቱን ማሳወቅ
4. ታካሚውብቻውንየ ሚላክከሆነ ለምነብቻውንእንደሚድክረዳት
5. የ ተለያዩየ ላቦራቶሪውጤቶችኮፒአልያምጽሁፍከ ታካሚውማክ ታላለፊያጋርሚያያዝ
6. ድንገተኛእናአጣዳፊህመምነከሆነ ታካሚውተቀባይየ ጤፍ ተቋምሙድረሱን ሚረጋገጥ

ከ ታካሚውጋርወደተቀባይተቋምየ ሚደውባለሞያታላፊነ ት

1. ከ ታካሚውሳንበሚሆንአስፈላጊውንእርዳታእያደረገ ሜድአለበት
2. ለ ተቀባዩ ተቋምየ ህመማን ቅብብሎሽእናላይዘንአፊስ ታካሚውን ማስተላለፍ
3. ታካሚውያለተግባቦትየ ተላከእንደሆነ የ ተጻፈለትንደብዳቤለ ተቀባዩ ሆስፒታልስራሃላፍ ዎችማክጠት
4. ታካሚውከ ተቀባይተቋምቅጥር ግቢውስጥአልያምውጭለሚከተለውጉዳትተጠያቂይሆ ናል

የ ተቀባይተቋምእና ተቀባይባለሞያታላፊነ ት

ተቀባይተቋም

1. የ ተላከውን ታካሚቀብሎየ ህክምና አገልግሎቱን ማስቀጠል
2. ለ ላኪውተቋምግብረ መልስ መላኩን ሚረጋገጥ

3. ላኪ ተቋም የሚያዋጅና ሌሎች ድጋፎችን በማድረግ ማገዝ
4. የህሙማን ቅብብሎሽ ስርዓቱን እና አገልግሎትትን ተና እና ምርመራ በየሶስት ወሩ ማሰራት

የተቀባይ ተቋም ባለሙያ ኃላፊነት

1. በማንኛውም ሰዓት የተደወለ ስልክ የማንሳት እና የማናገር እና የታካሚውን ሁኔታ ለተረኛው ሀኪም ማሳወቅ
2. የተላከለት ታካሚ ተቋሙ እስኪደርስ ካመጣው ባለሙያ የመረከብ እና የህክምና አገልግሎቱን ማስቀጠል
3. ለላከው ተቋም ለታካሚው ሁኔታ ማሳወቅ እና ለላኪው ተቋም ግብረ-መልስ መስጠት
4. ለታካሚው ወይም ለሚመለከተው አካል አስፈላጊውን መረጃ መስጠት

ከሶስተኛ ወገን ጋር የሚደረግ መግባቢያ

ይህ የመግባቢያ ሰነድ የህክምና አገልግሎቱን ጥራቱን በጠበቀ መልኩ የታካሚውን ፍላጎት ማዕከል ያደረገ አግልግሎት እንዲያገኙ ማስቻል ነው፡፡ ስለሆነም ሁሉም ላኪ እና ተቀባይ ተቋማት ተመሳሳይ አላማ ካላቸው ሌሎች የግል እና የመንግስት ተቋማት ጋር የህሙማን ቅብብሎሽን የመግባቢያ ሰነድ ይዘቱን ሳይለቅ ተፈራርመው ለክልል ጤና ቢሮ ማሳወቅ ይችላሉ፡፡ ሆኖም ይዘቱ የሚቃረን ከሆነ የክልል እና የጤና ሚኒስቴር ተሳትፎ ያስፈልጋል፡፡

ሚስጢራዊነት

ሁሉም ላኪ እና ተቀባይ ተቋማት የታካሚዎቻቸውን የግል ሚስጢር በህግ ካልታዘዙ በስተቀር የግል ሚስጢር መጠበቅ እና አስፈላጊ መረጃዎች በታካሚው ፍላጎት ለፈቀደላቸው ግለሰቦች ይሰጣል፡፡ ታካሚው በራሱ መወሰን የማይችል ከሆነ ለቅርብ (ባል፣ ሚስት፣ ልጅ፣ አባት) ብቻ የህክምና መረጃ ይሰጣል፡፡

የመግባቢያ ሰነድ ውሉን ስለማቋረጥ

የመግባቢያ ውሉ በጤና ሚኒስቴር እና ክልል ጤና ቢሮዎች እውቅና የህሙማን ቅብብሎሽ ስርዓቱ በሌላ መልኩ ሲተካ ይቋረጣል፡፡

ቅድመ ማሳወቅ

በዚህ የህሙማን ቅብብሎሽ የመግባቢያ ሰነድ ያልተዳሰሱ ጉዳዮች ወይም ያልታሰቡ እና ከአቅም በላይ የሆኑ ችግሮች ያጋጠሙ እንደሆነ ላኪውም ሆነ ተቀባዩ ተቋም ችግሩ በተፈጠረ በትእለት ለሌላኛው ተቋም ማሳወቅ ግዴታ አለበት፡፡ ጉዳዩ ከህሙማን ህይወት ጋር ቁርኝት ያላቸው በሆናቸው አካል ተገና

ኝቶእና በደብዳቤለተፈጠረውችግርየ ጋራጭትሄ ማስቀጣትያስፈልጋል፡ ፡ ይህሳይሆንቢቀርተጠያ ቂነቱንያላሳወቀውአካልጋርይሆናል፡ ፡

ያለመገባባትአፈታት

በመገባቢያውሰነ ድላይእና በህመማንቅብብሎሽአገልግሎትዙሪያበሁለቱተቋማትበተፈጠሩችግሮች በቅድሚያሁለቱተቋማትበማ ጋገርለመፍታትመሞከርአለባቸው ፡ በዚህሜልኩሊፈታካልቻለእንደ ሆስፒታሎቹተጠሪነ ትክልሎችበጉዳዩዙሪያግልጸኝነ ትእነ ዲኖርየ ሚድረግስራእና አቅጣጫዎችንያ ስቀምጣል፡ ፡

የ ሁለቱተቋማትግንኙነ ት

ይህንየ መገባቢያሰነ ድየ ተፈራረሙተቋማትየ ተለያዩእና እራሳቸውንየ ቻሉተቋማትናቸው ፡ የ ትኛ ውምተቋምጣሌላኛውተቋምአስተዳደራዊጉዳዮችጣልቃአይገባም፡ የ ሌላኛውተቋምውክልናየ ለውም ፡

የ መገባቢያሰነ ዱንስለማሻሻል

ይህመገባቢያሰነ ድበላኪእና ተቀባይተቋማትስምምነ ትማሳረትየ ሀገሪቱንህግበሚይጥስእና የ ጤፍ ሚኒስቴርያዘጋጀውንየ ህመማንቅብብሎሽስርዓቱንበሚይጥስሜልኩሊሻልይችላል፡ ፡

የ መገባቢያሰነ ዱህጋዊነ ት

ይህመገባቢያሰነ ድበሀገሪቱህግእና የ ህመማንቅብብሎሽመመሪያማሳረትይተገበራል፡ ፡

Annex VII: National Referral audit tool (separate Excel)