



2.10

Secondary/Tertiary Facility Survey

Person Conducting Interview:

Date(s) of Interview:

Facility Name and Country:

Facility Type

- | | | |
|--|------------------------------------|---|
| <input type="checkbox"/> Public/government | <input type="checkbox"/> Secondary | <input type="checkbox"/> District |
| <input type="checkbox"/> Private for-profit | <input type="checkbox"/> Tertiary | <input type="checkbox"/> Regional |
| <input type="checkbox"/> Private not-for-profit | | <input type="checkbox"/> Provincial |
| <input type="checkbox"/> Philanthropic/Charity/
NGO/faith-based | | <input type="checkbox"/> Other, please describe |

IEC/IRB Approval Number and Date	<input type="text"/>
Name of Person Providing Information:	<input type="text"/>
Title:	<input type="text"/>
Email (Primary):	<input type="text"/>
Email (Secondary):	<input type="text"/>
Mailing Address:	<input type="text"/>
Physical Address:	<input type="text"/>
GPS coordinates of facility:	<input type="text"/>
Phone (Office):	<input type="text"/>
Phone (Cell):	<input type="text"/>
Alternate Contact Person Name:	<input type="text"/>
Title:	<input type="text"/>
Email (Primary):	<input type="text"/>
Phone (Office):	<input type="text"/>
Phone (Cell):	<input type="text"/>
Training Programmes affiliated with this Facility:	Educational Institution Name/Location
<input type="checkbox"/> Medical Students	<input type="text"/>
<input type="checkbox"/> Specialists (Residents/Fellows)	<input type="text"/>
<input type="checkbox"/> Professional Nurses	<input type="text"/>
<input type="checkbox"/> Pharmacists	<input type="text"/>
<input type="checkbox"/> Other. Please specify	<input type="text"/>

Name:



Role of Key Informant for this section:

Date:

How much* do patients typically pay out of pocket for:	ARF	Acute RHD
Inpatient consultations	/day	/day
	Comment:**	Comment:**

Medications	Comments:	
Warfarin	/dose	
Penicillin (oral or benzathine)	/dose	
Aspirin	/dose	
ACE inhibitor (e.g., captopril, enalapril, lisinopril)	/dose	
Beta blocker (e.g., atenolol, carvedilol, propranolol)	/dose	
Spirolactone	/dose	
Furosemide (IV)	/dose	
Furosemide (oral)	/dose	
Digoxin	/dose	

Comments:**

Diagnostics	Comments:	
Chest Xray	/test	
Electrocardiogram	/test	
Full blood count	/test	
INR	/test	
Echocardiogram	/test	

Comments:

* May list in local currency or as a percentage of total costs, whichever is available.

** As in outpatient form, please describe any important exemptions (e.g., pregnant, HIV-positive)



Name:

Role of Key Informant for this section:

Date:

Service Area: Geographic and Number Served		
Number of Inpatient Beds		
Number of Theatres		
Number of Casualty Beds		
Service:	No. of beds / Typical Occupancy (Census)	No of Medical Officers /Specialists
General Medical	_____ / _____%	
General Surgical	_____ / _____%	
Intensive Care	_____ / _____%	
Obs/Gyn	_____ / _____%	
Paediatrics	_____ / _____%	
Orthopaedics	_____ / _____%	
Psychiatry	_____ / _____%	
Other Please specify.	_____ / _____%	
Other. Please specify.	_____ / _____%	
Does the facility have an intensive care unit?		<input type="checkbox"/> yes <input type="checkbox"/> no
ICU nurses?		<input type="checkbox"/> yes <input type="checkbox"/> no
Echocardiography?		<input type="checkbox"/> yes <input type="checkbox"/> no
Cath lab		<input type="checkbox"/> yes <input type="checkbox"/> no
Screening facilities for prosthetic valves?		<input type="checkbox"/> yes <input type="checkbox"/> no
Are there other facilities/resources available, which you feel are important in the ability to provide post-operative care? Comment:		<input type="checkbox"/> yes <input type="checkbox"/> no
Are there cardiac surgical rehabilitation programmes for patients and families?		<input type="checkbox"/> yes <input type="checkbox"/> no
Are cardiac surgical follow-up services provided? If yes, please describe		<input type="checkbox"/> yes <input type="checkbox"/> no



Name:

Role of Key Informant for this section:

Date:

Diagnosis and management of ARF

Are guidelines or criteria for diagnosis of ARF used?	<input type="checkbox"/> yes <input type="checkbox"/> no
- Which criteria are used? (please attach a copy)	
<input type="checkbox"/> Revised Jones Criteria	
<input type="checkbox"/> WHO Criteria	
<input type="checkbox"/> Other – please specify:	
- Are categories of diagnosis utilised? (for example: possible, definite, echo confirmed – please describe)	<input type="checkbox"/> yes <input type="checkbox"/> no
- What resources are available to aid diagnosis?	
<input type="checkbox"/> Thermometer	
<input type="checkbox"/> Stethoscope	
<input type="checkbox"/> ECG	
- Who reads and interprets the ECG?	
<input type="checkbox"/> Blood tests (see laboratory section for blood tests available)	
<input type="checkbox"/> Acute access to echocardiography	
- Who reads and interprets the ECHO?	
- Are people with suspected ARF admitted to hospital?	<input type="checkbox"/> yes <input type="checkbox"/> no
- Where is the diagnosis of ARF recorded?	<input type="checkbox"/> Unknown
<input type="checkbox"/> Patient's clinical notes	
<input type="checkbox"/> Patient held medical records	
<input type="checkbox"/> Diagnosis book	
<input type="checkbox"/> Register	
Are there guidelines for the management of ARF? (please attach a copy)	<input type="checkbox"/> yes <input type="checkbox"/> no
- What does management of ARF include?	
<input type="checkbox"/> Bed rest	
- recommended for how long?	
<input type="checkbox"/> Aspirin	
<input type="checkbox"/> Antibiotics	
<input type="checkbox"/> Steroids	
<input type="checkbox"/> Other (Please describe)	

Please describe what happens when someone is diagnosed with RHD:	
<input type="checkbox"/> Referral (please describe where to and how)	
<input type="checkbox"/> Education (please describe any patient education undertaken/in process)	
<input type="checkbox"/> Begins prophylaxis	
<input type="checkbox"/> Is given a prophylaxis card	
<input type="checkbox"/> Other, please describe	
A woman with RHD becomes pregnant:	
<input type="checkbox"/> Referral (please describe where to and how)	
<input type="checkbox"/> Education (please describe the education process)	
Someone with RHD is clinically deteriorating	
<input type="checkbox"/> Referral (please describe where to and how)	
<input type="checkbox"/> Admission to hospital (please describe where to and how)	
<input type="checkbox"/> Added to wait list for surgery	
<input type="checkbox"/> Palliative management (please describe process)	
Someone with RHD has symptoms of infective endocarditis	
<input type="checkbox"/> Referral (please describe where to and how)	
- Do you have access to blood cultures	<input type="checkbox"/> yes <input type="checkbox"/> no
- Do you have access to long-term IV antibiotics?	<input type="checkbox"/> yes <input type="checkbox"/> no
Someone with RHD has symptoms of stroke	
<input type="checkbox"/> Referral (please describe where to and how)	
- Do you have access to CT to establish whether ischemic or hemorrhagic?	<input type="checkbox"/> yes <input type="checkbox"/> no
- Do you have access to stroke rehabilitation services?	<input type="checkbox"/> yes <input type="checkbox"/> no
Someone with RHD dies. Is the cause of death recorded?	<input type="checkbox"/> yes <input type="checkbox"/> no
- Where?	
<input type="checkbox"/> Death certificate	
<input type="checkbox"/> Deaths book at clinic	
<input type="checkbox"/> Government agency	
- How is the RHD register notified?	



Name:

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Date:


Surgical/Interventional Services

Does your facility provide interventional services?	<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Balloon valvuloplasty	
<input type="checkbox"/> Valve repair	
<input type="checkbox"/> Bioprosthetic valve replacement	
<input type="checkbox"/> Mechanical valve replacement	<input type="checkbox"/> yes <input type="checkbox"/> no
- Can all patients have expert preoperative echocardiography locally?	<input type="checkbox"/> yes <input type="checkbox"/> no If yes, please supply details: _____
If services are referred to outside facilities, where are services delivered?	
Name of Referral Facility:	
<input type="checkbox"/> In the same country with local surgeons	
<input type="checkbox"/> In the same country with visiting surgeons	
How many visiting surgical providers are there?	
How often do they visit?	
<input type="checkbox"/> Patients travel overseas for interventions (informally arranged)	
<input type="checkbox"/> At regional center for excellence	
How many people have received cardiac surgery in the last 12 months? :	
Age distributions	
30-day mortality	
5-year mortality	
Morbidity	
Interviews with surgeons	
Are patients referred appropriately for surgery? Please elaborate.	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you see your patients for follow-up?	
What are the challenges in delivering surgical care?	

Access to Care/Surgical Options

Is there a wait listing of people who would benefit from surgical intervention for RHD?	<input type="checkbox"/> yes <input type="checkbox"/> no
Who decides which people would benefit from surgery?	

Please describe any clinical criteria used:	
What restrictions apply to someone considered suitable for surgery? (For example: adherence to previous therapy, geographic location, women of reproductive age.)	
Describe the process to discuss the waiting list and triage with surgical teams	
How many people are on the waiting list? As of what date?	
What is the estimated average time to be on the waiting list (in months)?	
How is the waiting list triaged?	
Is there a pre-operative work up protocol?	<input type="checkbox"/> yes <input type="checkbox"/> no
- Can all patients have expert preoperative echocardiography locally?	<input type="checkbox"/> yes <input type="checkbox"/> no
- Do all patients have dental review and optimisation?	<input type="checkbox"/> yes <input type="checkbox"/> no


 Name:
 Role of Key Informant for this section:
 Date: DD / MM / YYYY

Registers - Inpatient Admissions (Incidence and Prevalence)	
Please provide a copy of the data headings of the Inpatient Admission Register	
Does this facility record inpatient admissions by diagnosis?	<input type="checkbox"/> yes <input type="checkbox"/> no
Does this facility record inpatient discharges by diagnosis?	<input type="checkbox"/> yes <input type="checkbox"/> no
Total number of inpatient admissions over 12-month period. From: <input type="text"/> DD / MM / YYYY To: <input type="text"/> DD / MM / YYYY	
Total number of inpatient discharges over 12-month period (if applicable). From: <input type="text"/> DD / MM / YYYY To: <input type="text"/> DD / MM / YYYY	

Inpatient Mortality	
Does this Facility's Death Log include Cause of Death?	<input type="checkbox"/> yes <input type="checkbox"/> no
Is any information regarding deaths occurring outside of the facility captured? If yes, please describe.	<input type="checkbox"/> yes <input type="checkbox"/> no
Total number of all inpatient deaths over 12-month period. From: <input type="text" value="DD / MM / YYYY"/> To: <input type="text" value="DD / MM / YYYY"/>	
RHD Registers – Outpatient Services	
Please provide a copy of the data headings of the OPD Service Attendance Register	
Is a casualty/emergency department Admissions/Attendance Register maintained separately?	<input type="checkbox"/> yes <input type="checkbox"/> no
Number of people on the OPD register over 12-month period (or number of patients on Cardiac Clinic Register if provided) From: <input type="text" value="DD / MM / YYYY"/> To: <input type="text" value="DD / MM / YYYY"/>	
Is there an ARF/RHD Register?	<input type="checkbox"/> yes <input type="checkbox"/> no
Is this register populated per information provided from <input type="checkbox"/> Outpatient Services Only <input type="checkbox"/> Inpatient Services Only <input type="checkbox"/> Both In and Outpatient Services	
How many patients in total are on the Register? Total: _____ ARF: _____ RHD: _____	
What happens when people:	
- Move away and need to be referred to another register?	
- Move into the area and need to be added to the register?	
- Can't be contacted? Are they removed from the register?	
- How is 'loss to follow-up' defined	
- Die? Are they removed from the register?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are there registers for other diseases? i.e., tuberculosis, diabetes or others? If yes, please list: _____	<input type="checkbox"/> yes <input type="checkbox"/> no

Name:

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Date:

Laboratory services		Comments:
Does your facility have access to throat swabs and culture?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	
Does your facility have access to rapid GAS throat swabs?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	
Are the swabs sent for emm typing? If so, where?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	
Are records of invasive streptococci kept? If yes, please describe record-keeping process.	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	

Do you have access to these other laboratory services? (Tick as many as apply)

<input type="checkbox"/> Antistreptolysin O Titre (ASOT) <input type="checkbox"/> Available on site <input type="checkbox"/> Sent to off-site laboratory Days for results: _____	<input type="checkbox"/> C Reactive Peptide (CRP) <input type="checkbox"/> Available on site <input type="checkbox"/> Sent to off-site laboratory Days for results: _____	<input type="checkbox"/> Full blood count <input type="checkbox"/> Available on site <input type="checkbox"/> Sent to off-site laboratory Days for results: _____
<input type="checkbox"/> Anti DNase B (ADB) <input type="checkbox"/> Available on site <input type="checkbox"/> Sent to off-site laboratory Days for results: _____	<input type="checkbox"/> Erythrocyte Sedimentation Rate (ESR) <input type="checkbox"/> Available on site <input type="checkbox"/> Sent to off-site laboratory Days for results: _____	<input type="checkbox"/> International Normalised Ratio (INR) <input type="checkbox"/> Available on site <input type="checkbox"/> Sent to off-site laboratory Days for results: _____
<input type="checkbox"/> Blood cultures <input type="checkbox"/> Available on site <input type="checkbox"/> Sent to off-site laboratory Days for results: _____	Comments:	



Name:

Role of Key Informant for this section:

Date: / /

For Secondary/Tertiary Facilities that Provide an Outpatient Cardiology/RHD/INR Service

Do you keep a record of all patients visiting the clinic?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you keep a record of patients referred for further treatment?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you keep a list of patients who are on prophylaxis?	<input type="checkbox"/> yes <input type="checkbox"/> no
What proportion of RHD patients are on secondary prophylaxis? (Estimate)	
Proportion of patients on injection prophylaxis: _____ %	
Proportion of patients on oral prophylaxis: _____ %	
How do people access Secondary Prophylaxis?	
<input type="checkbox"/> Provided by OPD Clinic or Pharmacy	
- Who do you notify when more stock is needed?	<input type="checkbox"/> Don't know
<input type="checkbox"/> Purchased by patients at the health center	
<input type="checkbox"/> Purchased by patients from other pharmacies	
Approximately how often do patients miss out on secondary prophylaxis because medication is out of stock?	<input type="checkbox"/> Don't know
What happens when medication is out of stock or can't be provided?	<input type="checkbox"/> Don't know
<input type="checkbox"/> Patients told to return later	
<input type="checkbox"/> Oral alternative offered	
<input type="checkbox"/> Patients told to buy supply privately and bring in for administration	
<input type="checkbox"/> Other: please outline	
Are any strategies in place to encourage adherence? Please describe.	<input type="checkbox"/> Don't know
Are there guidelines on the frequency of secondary prophylaxis injections	<input type="checkbox"/> Don't know
<input type="checkbox"/> Two weekly	
<input type="checkbox"/> Three weekly	
<input type="checkbox"/> Four weekly	
<input type="checkbox"/> Other: please describe	
Is the dose of BPG altered for children? Please describe how.	<input type="checkbox"/> Don't know
Who delivers secondary prophylaxis injections?	<input type="checkbox"/> Don't know
<input type="checkbox"/> Community health workers	
<input type="checkbox"/> Registered nurses	
<input type="checkbox"/> Doctors	
<input type="checkbox"/> Other: please describe	

Is training provided on:	
<input type="checkbox"/> Intramuscular injection technique	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know
<input type="checkbox"/> Diagnosis and emergency management of anaphylaxis	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know
Are any techniques used to minimise the pain of injection?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know
Are any techniques used to encourage / incentivise attendance?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know
Are patients also able to access secondary prophylaxis at	
<input type="checkbox"/> Primary health clinics	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know
<input type="checkbox"/> As part of an outreach programme in homes	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know
<input type="checkbox"/> In schools	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know
<input type="checkbox"/> Other: please describe	
Are injections recorded when they are given	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know
- Where are they recorded?	
<input type="checkbox"/> Patient held injection books	
<input type="checkbox"/> Injection books at the clinic	
<input type="checkbox"/> Notified to the register	



Name:

Role of Key Informant for this section:

Date:

OPD Pharmacy Service when Associated with Secondary/Tertiary Facility

What is your most common formulation of BPG?

Premixed liquid

- Do you have problems with

Maintaining a cold chain

Anaphylaxis or adverse drug reactions

Other, please describe

Powder for reconstitution

- Do you have problems with

Difficulty reconstituting powder

Breakthrough episodes of ARF on prophylaxis

Intermittent supply of powdered BPG

Anaphylaxis or adverse drug reactions

Other, please describe:

- What is the powder mixed with? _____

What volume? _____

Do you have a supply of adrenaline to manage anaphylaxis?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know
Has your programme had any deaths from anaphylaxis or adverse drug reaction in the last 12 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know
- How many?	
- Please describe events, community and staff reactions in as much detail as possible	
Which of these drugs are regularly stocked in your Outpatient/ Clinic Pharmacy?	<input type="checkbox"/> Don't know
<input type="checkbox"/> Oral frusemide	
<input type="checkbox"/> IV frusemide	
<input type="checkbox"/> Spirinolactone	
<input type="checkbox"/> Any beta blocker	
<input type="checkbox"/> Any ACE inhibitor	
<input type="checkbox"/> Aspirin	
*Anticoagulants and vitamin K outlined in Anticoagulation section	
What forms of contraception are freely available?	<input type="checkbox"/> Don't know
<input type="checkbox"/> Oral contraceptive pill	
<input type="checkbox"/> IUD	
<input type="checkbox"/> Implantable subdermal implants	
<input type="checkbox"/> Barrier contraception	
	Comment:
Who orders supplies of BPG?	<input type="checkbox"/> Don't know
Who are they purchased from?	<input type="checkbox"/> Don't know
Who pays for them?	<input type="checkbox"/> Don't know
How is stock tracked and new stock ordered?	<input type="checkbox"/> Don't know
What brand(s) of BPG do you use?	<input type="checkbox"/> Don't know
Cost of BPG	<input type="checkbox"/> Don't know
Any other antibiotics used?	<input type="checkbox"/> Don't know
Challenges in accessing supply? (i.e. transport, ordering, stock level monitoring)	<input type="checkbox"/> Don't know
Pharmacy site visit: Date: Name and Title of Person in Charge: Observations:	
Photographs of BPG vials, count total number, record expiry date, collect samples for analysis.	



Name:

Role of Key Informant for this section:

Date:

Anticoagulation Criteria and Management		Comments:
What are the local clinical indications for warfarin?	<input type="checkbox"/> Don't know	
<input type="checkbox"/> Mechanical prosthetic valve replacements		
<input type="checkbox"/> Atrial fibrillation		
<input type="checkbox"/> Heart failure		
Is there access to other anticoagulants?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	
<input type="checkbox"/> Aspirin		
<input type="checkbox"/> Heparin by infusion		
<input type="checkbox"/> Low molecular weight heparin (ie enoxaparin, clexane)		
<input type="checkbox"/> Thienopyridine antiplatelet agents (plavix, clopidogrel)		
INR Management Clinic when associated with Secondary/Tertiary Facility		Comments:
How many patients are on warfarin?	<input type="checkbox"/> Don't know	
Do patients on warfarin have their INR monitored?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	
- Where can people get their INR checked?	<input type="checkbox"/> Don't know	
<input type="checkbox"/> Local primary care clinic		
<input type="checkbox"/> Local pharmacy		
<input type="checkbox"/> Local laboratory		
<input type="checkbox"/> Local INR clinic		
<input type="checkbox"/> Only in secondary or tertiary settings		
- Are the tests		
<input type="checkbox"/> Venous blood samples	<input type="checkbox"/> Don't know	
- Where are blood tests sent?	<input type="checkbox"/> Don't know	
- How are results reported (i.e.: phone, electronic, paper)	<input type="checkbox"/> Don't know	
- How many days does it take for results to come back	<input type="checkbox"/> Don't know	
<input type="checkbox"/> Finger prick point-of-care machines	<input type="checkbox"/> Don't know	
Who is responsible for altering the dose of warfarin?	<input type="checkbox"/> Don't know	
Do you have access to Vitamin K warfarin reversal?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	
Is there record book of INR results?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	

Do patients keep their own copy of INR records?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	
Do patients pay for INR testing?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	
- How much does one INR test cost?	<input type="checkbox"/> Don't know	
Approximately how often do stable patients have their INR checked? _____ /year	<input type="checkbox"/> Don't know	



Name: _____

Role of Key Informant for this section: _____

Date: DD / MM / YYYY

Medical Records	Comments:
Inpatient and Outpatient Clinic Records are consolidated into one record?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Records are kept in <input type="checkbox"/> Paper only <input type="checkbox"/> Both Electronic and Paper Comments:	
Records are archived after how many years? _____ When are Death Records archived? _____ Please describe other criteria for archiving.	
Archived records are kept For how many years? _____ <input type="checkbox"/> On site? Please describe location. <input type="checkbox"/> At a remote location? Please describe location.	
Are cause of death details recorded in the Death Register? Please provide data headings of this Register.	<input type="checkbox"/> No <input type="checkbox"/> Yes



Name: _____

Role of Key Informant for this section: _____

Date: DD / MM / YYYY

Morgue Operators	
Are cause of death details recorded at morgue?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is there an autopsy record book?	<input type="checkbox"/> No <input type="checkbox"/> Yes